OREGON CONFERENCE OF SEVENTH-DAY ADVENTISTS
BIG LAKE YOUTH CAMP
19800 Oatfield Rd.
Gladstone, OR 97027
Phone: 503.850.3551 Fax: 503.850.3451
debbie@biglake.org

EMERGENCY INFORMATION AND MEDICAL PERMISSION FORM MINOR STAFF

Name: _____ Birth Date: _____ ☐ Male ☐ Female

Address: _____ Phone: _____

Permanent Address (If different then above): _____

_____ Permanent Phone: _____

Physician's name, Address & Phone:

_____

_____

In case of emergency, please contact:

1. Name: _____ Relationship: _____
   Address: _____Phone: _____

2. Name: _____ Relationship: _____
   Address: _____Phone: _____

HEALTH AND MEDICAL INFORMATION

Please list any medical conditions/concerns, recent injury, or hospitalization that might require special planning or consideration during your staff member's involvement with Outdoor School activities.

_____

_____

_____

Specify any activities that are not allowed: _____

Date of last tetanus (if known) _____

Allergies, and reaction (food, medication, other):

_____

_____

Dietary Restrictions_____

_____

Recent exposure to infectious disease: _____
Attach an additional sheet if there is any information you wish to share that is related to your well-being.

Medications

1. We ask that counselors turn in all prescriptions and over-the-counter medications to the nurse. Teachers and staff are encouraged to turn medications into the nurse as well.
2. Prescription and over-the-counter medications must be in original container.

I am taking the following medications and will bring them to Outdoor School.

Medication	Reason	Dosage	Time	Physician & Phone #

PERMISSION FOR ADMINISTRATION OF EMERGENCY CARE

This health history is correct, and the person herein described has permission to engage in all prescribed activities, except as noted by me and/or the Outdoor School physician/nurse. In the event I cannot be reached in an emergency, I hereby give my permission to the Outdoor School medical support person to arrange appropriate transportation, hospitalize, secure proper anesthesia, or to order injection or surgery for my son/daughter. I also give permission to the physician/nurse to give over-the-counter medication including but not limited to pain medication and cold/flu medication.

_____

Minor's Name

_____ _____

Parent Signature Date