CHURCH NAME/CITY: _____ **EVENT ATTENDING:**_____ **DATE(S):**_____

OHIO MINISTRY NETWORK STUDENT MINISTRIES EMERGENCY MEDICAL AUTHORIZATION AND INFORMATION FORM

First Name: _____ Last Name: _____ Date of Birth: _____Age:____ Gender at Birth (circle one): M F
Address: _____ City: _____ State: _____ Zip: _____ Home Phone:_____
Parent or Legal Guardian(s) Name(s):_____
Work Phone Number (Dad):_____ Work Phone Number (Mom): _____
Cell Phone Number (Dad): _____ Cell Phone Number (Mom): _____
Emergency Contact (If Parent or Guardian cannot be reached) Name: _____ Relation: _____ Phone:_____
Medical Insurance Company: _____ Policy Number:_____

For events at Heartland Conference Retreat Center, many generic over-the-counter medications a student might need are provided including Tylenol, Advil, Benadryl, Tums. Please do not send over-the-counter medications unless it is something very specific (i.e. Zyrtec, Claritin, etc.).

Due to Federal and State Law ALL medications must have the current prescription label, be in the name of the student taking the medication, and in their original bottle *(prescriptions in the prescription bottle, supplements in their original bottle). All medication will be given according to the dosing instructions. If they have changed, we must have a note with the changes and the doctor's signature.* ***We cannot give a medication unless it meets the criteria listed above.***

Please list any medications that your child will be taking while at camp. Please send only the amount of medication needed for the camp trip.

Name Of Medication	Dose	Reason for Medication	When Taken
Example: Erythromycin	1 pill, 4 times a day	Asthma	Breakfast, Lunch, Dinner, Bedtime

I give permission for my child to self-carry their emergency medication(s): ____Yes ____No (***If yes***, please send a copy of the self-carry form signed by a physician)

If you need more room for the medications or health history, please use the back side. Thanks!

Health History (please check if applicable)
____Convulsions/Seizures ____Bedwetting ____ Diabetes
____Bleeding/Clotting disorders ____Sleepwalking ____Asthma

Other potential health problems (please list)
_____
_____
_____
_____

Allergies (please check if applicable)
___Bee stings ___Allergies to medication (please list) _____

___**FOOD ALLERGIES** (please list)_____
_____

___**FOOD RESTRICTIONS** (please list) _____
_____

REQUIRED FOR EACH YOUTH CAMPER: I HEREBY GIVE PERMISSION TO THE OHIO MINISTRY NETWORK (OMN) AND HEARTLAND TO SECURE EMERGENCY MEDICAL AND SURGICAL TREATMENT. ALSO TO PROVIDE ROUTINE, NON-SURGICAL MEDICAL CARE FOR THE MINOR CHILD NAMED ABOVE WHILE ATTENDING THE ABOVE NAMED CAMP. I RELEASE ALL PHOTOS, VIDEO AND AUDIO TAPES OF MY CHILD TO OMN AND HEARTLAND FOR PROMOTIONAL PURPOSES SUCH AS BROCHURES, VIDEO, WEB PAGES, ETC. I HEREBY GRANT PERMISSION FOR MY CHILD TO PARTICIPATE IN THE EVENT ACTIVITIES INCLUDING THE OUTDOOR ENVIRONMENTAL EXPERIENCES AND ACCEPT ANY RISKS INVOLVED IN HIS OR HER PARTICIPATION AS WELL AS PERSONAL FINANCIAL RESPONSIBILITY FOR ANY INJURY OR LOSS SUSTAINED DURING THE ACTIVITIES AND HOLD OMN AND HEARTLAND HARMLESS FOR SUCH INJURY OR LOSS ARISING DIRECTLY OR INDIRECTLY FROM SAID ACTIVITIES.

I certify that this information is true to the best of my knowledge.

_____

Parent or Legal Guardian Signature **Date**

Rev 10.2017