

# 2026 SUMMIT CAMP MEDICAL RELEASE

Please complete this form so we can provide proper care for your student at camp.  
A completed health form is required for all Summit Camp activities.



## SECTION I - BASIC CONTACT INFORMATION

---

Name: \_\_\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_

Home Address: \_\_\_\_\_  
Street City State ZIP

Social Security #: \_\_\_\_\_ Gender: M F

Camper Lives With: Mother & Father Mother Father Grandparent Other \_\_\_\_\_

Custodial Parent/Guardian: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Home Address: (if different) \_\_\_\_\_  
Street City State ZIP

If not available in an emergency, please notify: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Family Physician Name \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Dentist/Orthodontist Name \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

## SECTION II - TRANSPORTATION

---

In order to protect your child, please provide us with the following information:

Who will be picking your child up at Davis & Elkins College at the close of camp?

Name: \_\_\_\_\_

Is there anyone whom you do not want to pick up your child at the close of camp? If yes, please list name(s) \_\_\_\_\_

**SECTION III - INSURANCE INFORMATION** : Please include a copy of your insurance card and fill out the information below in the event of needing prompt health care for your child.

---

Is the participant covered by family medical/hospital insurance: YES NO

If so, indicate carrier or plan name: \_\_\_\_\_ Group # \_\_\_\_\_

Carrier Address: \_\_\_\_\_

Address for Claims: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Policy Holder's Insurance ID #: \_\_\_\_\_ Employer: \_\_\_\_\_

Policy Holder's Social Security #: \_\_\_\_\_ Policy Holder's Date of Birth: \_\_\_/\_\_\_/\_\_\_



## SECTION IV- MEDICATIONS AND RESTRICTIONS

Will camper be taking medications while at camp? Yes No

*\*\*Medications include prescription, over-the-counter, vitamins, inhalers, etc.*

If camper will be taking medications while at camp, please list all (prescription and non-prescription). Include the medication name, prescribing physician, physicians' phone number, and the dosage instructions. Use an additional sheet if needed. When checking in at camp, please provide all medications in their original packaging that identifies the prescribing physician (if prescription drug), the name of the medication, the dosage, and frequency of administration.

NAME OF DRUG	DOSAGE AMOUNT	TIMES GIVEN	DAILY DOSE	REASON FOR MEDICATION	NOTES:
Example: Mellaril	50 mg	8 am & 5 pm	100 mg	Behavioral	Crush pill

Identify any medications the camper takes during the school year that the camper does not/may not take during the summer: \_\_\_\_\_

Prescribing Physician: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

I grant permission for the camp health director to administer:

*\*\*Please circle your choice for each over-the-counter medicine below*

**Aspirin** Yes No                      **Non-Aspirin** Yes No                      **NSAID** (ibuprofen/Advil, Motrin) Yes No

**Cough Medicine** Yes No                      **Benadryl** Yes No                      **Pepto-Bismol** Yes No

**Maalox** Yes No                      **Imodium** Yes No

Parent/Guardian Signature for over-the-counter administration \_\_\_\_\_

**Special Instructions or Considerations for Minor Illness** *Please provide information (past and present) on any illnesses, injuries (i.e. broken bones, concussions, asthma, etc.) or special instructions for minor illnesses. Unless specific instructions are provided, camp health care staff will treat minor illnesses with over the counter medications. If illness persists, parents will be notified.*

Has your child ever been put in concussion protocol? Yes No                      If so, when? \_\_\_\_\_

*Any change to this form should be provided to camp health personnel upon camper's arrival in camp.*



## SECTION V - ALLERGIES

---

Camper does not have any allergies.

Camper is allergic to:

- Hay Fever       Poison Ivy/Oak       Insect Stings       Certain Foods  
 Penicillin       Other Drugs: \_\_\_\_\_

Please specify allergy and describe reaction and treatment.

---

---

---

## SECTION VI - AUTHORIZATION

---

**Parent/Guardian Authorizations:** This health history is correct and complete to the best of my knowledge, and the person described herein has permission to participate in all camp activities, except as noted. I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, and treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary transportation for me and/or my child. In the event I cannot be reached in an emergency, I give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp. I understand that all reasonable attempts will be made to contact me as soon as possible after a condition requiring treatment arises, and that, if I cannot be reached, all reasonable efforts will be made to contact the alternate listed above. I also understand that all reasonable precautions will be taken to ensure safety at all times. I further release the West Virginia Convention of Southern Baptists, Davis & Elkins College, and all persons associated with these organizations from any liability related to any accident, injury, or illness involving the individual named on this form.

\_\_\_\_\_  
SIGNATURE OF PARENT/GUARDIAN OR ADULT CAMPER/STAFFER

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PRINT FULL NAME