

RCC MEDICAL RELEASE FORM

Name _____

Physician _____ City _____ Phone _____

Family Medical Insurance Co. _____ Phone _____

Group Number _____ Policy Number _____

Date of Last Tetanus Shot _____

Indicate any physical condition or special needs our sta needs to know about: _____

Medications to be taken at camp _____

Allegeries, Medication that **cannot** be taken _____

Over-the-counter allergy, pain relievers, or fever-reducing medicines may be administered to my child.

Yes

No

Signature / Approval

We (I) authorize the camp director or his designee to secure medical or surgical treatment as recommended by a physician for the applicant's wellbeing. The camp health director or nurse may administer any prescribed medications and treat any emergency that may arise while the applicant is at Rockford Christian Camp.

Father/guardian **✗** _____ Phone day () _____ - _____

Mother/guardian **✗** _____ Phone day () _____ - _____

Rockford Christian Camp
PO Box 5966
Rockford, IL 61125

(815) 874-4041