The Jordan Crossing Camp
Medical Release Form

Print Attendee's Last Name, First Name: _____

This form is required from everyone attending an Camp with The Jordan Crossing Ministries, Inc. – June 27th thru July 1st 2022. All minors must have the bottom of this form:
Signed by their parent or legal guardian andnotarized.

_____
Your Church/Group Name (City, State)

Emergency Information

STUDENTS fill out each line below. ADULTS we only need your emergency contact.

Father_____**Work#**_____**Cell#** _____

Mother_____**Work#**_____**Cell#** _____

Legal Guardian (if different) _____**Cell#** _____

Emergency Contact (if different)_____**Cell#** _____

Parent or Guardian E-Mail Address: _____

Student E-Mail Address: _____

Patient's Name: _____ **Age:**_____

Address:_____**Home Phone#** _____

Birth Date:_____**Last Tetanus** _____

Allergies to Drugs: _____

Prescription Medication	Dosage	Times Given	Reason

Allergies to Foods: _____

Other Allergies: _____

All prescription medication must be in the original container from the pharmacy with the camper's name and current directions and dosage for the medications on the typewritten label. The non-prescription medications that will be available at camp on an as needed basis are Tylenol, Ibuprofen, Benadryl, Zyrtec, antibiotic ointment, and Tums. If you would like your camper to have any other non-prescription medication at camp, please send it in the original container with your camper's name on the container. Medication will be administered by Camp personell according to the directions on the label.

Physician/Phone# _____

Insurance Provider / Policy # / Insurance Phone (copies of insurance cards would be helpful but are not required:

_____

Authorization to Treat Minor

I swear (affirm), under penalty of perjury, that I am the parent/legal guardian of the child listed above, and that all information contained in this authorization is true and correct. I do hereby authorize treatment of my child by a licensed medical physician in case of any accident or illness that may arise, or should hospitalization be necessary.

Signature:_____**Name Printed:** _____

Sworn to and subscribed in my presence by _____this _____ Day of _____ 2022

My Commission Expires _____

Mailing Address: 5683 E State Hwy AF, Fair Grove, Missouri 65648

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