

DEEP IMPACT PARTICIPANT MEDICAL FORM (Page 1 of 2)

NAME _____ AGE _____ DATE OF BIRTH ___/___/___ SS# _____ - _____ - _____
Parents Name _____ PHONE () _____ - _____
Mailing Address _____
In case of emergency notify: _____ PHONE () _____ - _____ Relation _____
NAME OF CHURCH _____ PHONE () _____ - _____

MEDICAL PROFILE

GENERAL HEALTH (check one) __Excellent __Good __Fair __Poor
If FAIR or POOR please explain condition _____
LIST ANY MEDICAL DIFFICULTIES FOR WHICH YOU ARE CURRENTLY BEING TREATED _____

LIST ANY MEDICINES OR SUBSTANCES TO WHICH YOU ARE ALLERGIC _____

LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING _____

LIST ANY PREVIOUS OPERATIONS OR SERIOUS ILLNESSES _____

LIST ANY SPECIAL DIET (for medical purposes) _____

CHECK CHILDHOOD DISEASES:
[]CHICKEN POX []MEASLES []MUMPS []WHOOPING COUGH []OTHER
(list) _____
DATE OF TETANUS IMMUNIZATION: ___/___/___
FAMILY PHYSICAN _____

INSURANCE INFORMATION

INSURANCE COMPANY _____ POLICY # _____
SUBSCRIBER NAME _____ DOB of Subscriber _____
SUB. # _____
PLACE OF EMPLOYMENT _____ OCCUPATION _____
WORK PHONE NUMBER () _____ - _____ OTHER CONTACT NUMBER () _____ - _____

PERMISSION TO TREAT AND PHOTO/VIDEO NOTICE

My permission is granted for the DEEP IMPACT STAFF, CHURCH OFFICIAL, or ADULT present or in charge to obtain necessary medical attention in case of sickness or injury to my camper. I also understand that as a participant, my child may be photographed or videotaped during the normal DEEP IMPACT camp activities and these photos/videos may be used in promotional materials.

I, the undersigned, do hereby verify that the above information is correct and I do hereby release and forever discharge all sponsors, the Baptist State Convention of North Carolina and their employees and North Carolina Baptist Men from any and all claims, demands, actions or cause of action, past, present, or future arising out of any damage or injury while employed by or participating in DEEP IMPACT.

-Please complete and sign below (students under 18 years of age requires parent/custodial signature-

DEEP IMPACT PARTICIPANT MEDICAL FORM (Page 2 of 2)

PARTICIPANTS SIGNATURE _____ DATE ___/___/___

PARENT/CUSTODIAL SIGNATURE _____ DATE ___/___/___

PARENT/CUSTODIAL NAME (print) _____

NOTARY PUBLIC

On this the ____ day of _____, 20____, personally appeared before
me _____,

Personally know by me, and in my presence executed the within an foregoing permission and release
form.

Witness my hand and official seal this _____ day of _____, 20____.

My commission expires _____

_____, Notary Public.

***Please photo copy the student's insurance card front and back below.**