IEBA Winter Camp 2021

MEDICAL/PHOTO/VIDEO AUTHORIZATION

(To be filled in by parent/guardian or adult participant)

**Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date \_\_\_\_\_\_\_\_Sex\_\_\_\_\_\_\_ Age \_\_\_\_\_\_\_\_\_**

 **Last First M.I.**

**Parent/Guardian (or spouse) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Area/Number**

**Home address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Street & Number City State Zip**

**If not available, in an emergency notify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_**

 **Name Area/Number**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Street & Number City State Zip**

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**HEALTH HISTORY: (Check-giving approximate dates)**

**Allergies:­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Illnesses Requiring Medication:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Other Diseases or details of above:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of dentist/orthodontist \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of family physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you carry family medical/hospital insurance? \_\_\_\_ Carrier: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Suggestions from parents: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Other Medications:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### IMPORTANT – MUST BE COMPLETED FOR ATTENDANCE

 Parent’s Authorization: This health history is correct so far as I know, and the person herein described has

permission to engage in all prescribed activities except as noted: I hereby give permission to the physician selected by the IEBA Winter Camp staff, or the authorized church youth sponsor to order x-rays, routine tests and treatments for the health of my child, and in the event I cannot be reached in an emergency, I hereby give permission to the physician selected by Camp Director to transport, hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for my child as named above. I further agree to pay reasonable costs for medical treatment rendered. *Also, I understand that as a participant, my child may be photographed or videotaped during normal event activities and these photos/videos may be used in promotional materials.*

 I, the undersigned, do hereby verify that the above is correct and I do hereby release and forever discharge all sponsors, the Northwest Baptist Convention and employees, and any church 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 the IEBA Summer Camp.

#  Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_

# Concussion Awareness

At Winter Camp there may be snow and ice it is important that if your student falls and hits their head they see the nurse immediately so their injury can be properly assessed. Please go over the signs and symptoms of a concussion with your student and note that if your student falls and does not see a nurse to be assess they may be sent home at the parent’s expense. Your student’s safety is extremely important to us.

After the Fall did the Student?

* Appears dazed or stunned.
* Forgets an instruction, is confused about an assignment or position, or is unsure of the game, score, or opponent.
* Moves clumsily.
* Answers questions slowly.
* Loses consciousness *(even briefly)*.
* Shows mood, behavior, or personality changes.

Symptoms to Report

* Headache or “pressure” in head.
* Nausea or vomiting.
* Balance problems or dizziness, or double or blurry vision.
* Bothered by light or noise.
* Feeling sluggish, hazy, foggy, or groggy.
* Confusion, or concentration or memory problems.
* Just not “feeling right,” or “feeling down”

I have gone over these with my student and we fully understand the signs and symptoms of a concussion. My student agrees to see the nurse if he/she falls and hits his/her head to be evaluated for a concussion.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Name Student Name

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Parent/ Guardian Signature Student Signature

Concussion information found from the cdc website <https://www.cdc.gov/headsup/basics/concussion_symptoms.html>