

**CONSENT FOR MEDICAL TREATMENT
AND SPECIAL POWER OF ATTORNEY**
(Must be notarized)

Camper/Youth Participant Name: _____

The undersigned parent(s) or legal guardian(s) of the above-named Camper/Youth Participant do hereby appoint the Desert Southwest Annual Conference of The United Methodist Church (the "Conference") as attorney-in-fact with full power to act in the place and stead of the undersigned, during the period of six (6) months from the date set forth below, in connection with any and all activities sponsored by the Conference or any of its agencies in which the Camper/Youth Participant may be engaged, for the purpose of providing, authorizing and making all decisions concerning medical treatment for the Camper/Youth Participant, including without limitation emergency medical care, hospitalization and surgery, which the Conference, together with any attending physician, deem necessary for the care and safety of the Camper/Youth Participant during or in transit to or from the Conference-sponsored activities. The Conference may exercise this special power of attorney from time to time through any of its designated adult employees or agents and may demonstrate the existence of the authority granted hereby by presentation of either the original or a photocopy of this Consent for Medical Treatment and Special Power of Attorney. The undersigned consent to all such medical treatment and take full responsibility for any financial cost, which may be incurred in connection with the medical treatment of the Camper/Youth Participant.

Dated this _____ day of _____, ~~2005~~ ²⁰⁰⁷

Parent(s)/Guardian(s) Signatures(s)

Home Telephone

Address

Business Telephone

Subscribed and sworn before the undersigned notary public of the State of _____

County of _____, this _____ day of _____

Notary Public

My Commission Expires: _____

This Consent for Medical Treatment and Special Power of Attorney has been prepared by our Conference Chancellor. It meets the needs as interpreted in current Arizona and Nevada Law. Current law interpretation requires that the form be notarized and must be witnessed by a third party. This Consent for Medical Treatment and Special Power of Attorney is valid for all Annual Conference sponsored events for six months. A photocopy or fax of this form has the same validation as the original.

Make Three Copies

Bring copy of form to camp; keep a copy at home; send the original to:

Camp Registrar, 1550 E. Meadowbrook, Phoenix, AZ 85014-4040

(Please send no later than 2 weeks prior to event)

REQUEST FOR GIVING MEDICATIONS

Camper/Youth Participant Name: _____

In order to provide the safest administration of your camper/youth medication(s), please be sure that the medication(s) is/are labeled with the following:

- A) Camper/youth's name;
- B) Name and dose of medication
- C) Current directions for giving the medication, including time(s) to be given and any special instruction(s), i.e., "give with food," etc.

Sending medication(s) in original container(s) with the above information is mandatory.

It is essential that, if a camper/youth is currently on routine medication(s), that she/he remain on the medication(s) during the camping experience. Giving a child a "holiday" away from medication(s) during the camping experience can be very dangerous and counter-productive.

If it is necessary to give "over-the-counter" medication to my child, I give my permission to give her/him acetaminophen "Tylenol," which is stocked _____ (Init.). (No aspirin or products containing aspirin will be administered, unless ordered by a physician). I will provide any other analgesic "pain reliever," if preferred over acetaminophen. If deemed necessary, I give my permission for the administration of "over-the-counter" antihistamine (for allergic reactions) _____ (Init.) and antacids (for "upset" stomach) _____ (Init.), in dose appropriate to age.

Parent/Legal Guardian Signature: _____ Date: _____

****This part is to be completed ONLY if your child will be bringing medication(s).
Please bring this page with the medication. Fill out a different page for each medication.**

Name of Medication: _____ Rx No. _____

Times of day to be given: _____ A.M. _____ P.M.

Method of giving dosage e.g., By injection _____

Amount of each dosage e.g., one tablet, one teaspoonful, 1.0 oz _____

Date - From _____ To _____

Reason for Medication: _____

Person designated to administer medication e.g., Nurse, Self _____

Parent/Legal Guardian Signature: _____ Date: _____

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(Please send no later than 2 weeks prior to event)**

HEALTH FORM

(For Campers, Graduating Seniors, Cabin Assistants, and Anyone under 18 year of age)

Make Three Copies: Bring copy of form to camp; keep a copy at home; send original to:
Camp Registrar, 1550 E. Meadowbrook, Phoenix, AZ 85014-4040
(Please send no later than 2 weeks prior to event)

AFTER READING THE INSTRUCTIONS CAREFULLY, PLEASE COMPLETE BOTH SIDES OF THIS FORM. ADDITIONAL RELEVANT INFORMATION MAY BE ATTACHED ON A SEPARATE SHEET. ALL INFORMATION IS VERY IMPORTANT TO ENSURE THAT YOUR CAMPER/YOUTH HAS A HEALTHY AND SAFE CAMP EXPERIENCE. FAILURE TO FOLLOW ALL INSTRUCTIONS MAY RESULT IN YOUR CAMPER/YOUTH BEING SENT HOME.

- We do not have prescription medication, breathing machines, or anti-bed wetting drugs stocked at camp.
- If your camper/youth is on any medication or has special equipment, even if used infrequently, please send it along.
- Current weight is vital for correct medication dosage, especially in an emergency
- All medications except inhalers must be left with the nurse.
- **Food Service Information:** Camp meals are planned and prepared with attention to nutrition, variety, and appeal to the particular age-level group being served. Most meals served accommodate vegetarian diets. Persons on highly restricted diets due to medical necessity, food allergies, or personal choice diets, including vegans, will need to supplement the camp menu by providing their own prepared foods.

Call the Camping office at (602) 266-6956 ext 215 or 1(800) 229-8622 (outside Metro area) if you have any questions.

Name: _____ Birth Date: _____ Age: _____ Sex: _____
(Last) (First) (Itl) (MM/DD/Year)
Current Weight in pounds: _____

Parent or Guardian: _____ Telephone: (H) _____

Residence Address: _____ Telephone: (W) _____

City: _____ State: _____ Zip: _____ Telephone (Cell) _____

In an emergency notify: _____ Telephone _____
(other than above)

Address: _____ City _____ State: _____ Zip: _____

INSURANCE INFORMATION

CAMPER/YOUTH NAMES _____ S.S. #: _____

Medical Insurance Co.: _____ Policy Number: _____

Group Subscriber's Name: _____ Insured's Name: _____

Insurance Co. Phone # _____

CAMPER'S COVENANT

I, the undersigned, as a participant of a Desert Southwest Conference Camp, will cooperate in every way with the leaders of this camp. I will involve myself with camp activities offered. I will not bring any type of weapon(s), or use any tobacco products, alcohol or drugs, except for prescribe medical purposes. I will be responsible to the adult leadership of the camp for the duration of the camp. I will behave as a Christian person at all times.

Signature of camper _____ Date _____

HEALTH HISTORY:

(Check – giving approximate dates)

Abscessed Ear(s): _____	Constipation: _____	Rheumatic Fever: _____
Allergies: (see below) _____	Diabetes: _____	Scarlet Fever: _____
Appendicitis: _____	Diphtheria: _____	Sinusitis: _____
Asthma: _____	Fainting: _____	Sleep Walking: _____
Athlete's Foot: _____	German Measles: _____	Sore Throat: _____
Bed Wetting _____	Heart Trouble _____	Stomach Upset: _____
Bronchitis: _____	Kidney Trouble: _____	Sumac/Ivy Poison: _____
Chicken Pox: _____	Measles: _____	Tonsillitis: _____
Colds (frequent): _____	Mumps: _____	Tuberculosis: _____
Convulsions/Epilepsy: _____	Pneumonia _____	Whooping Cough _____

Operations or Serious Injuries: _____
Emotional/Behavioral/Learning Concerns: _____
Allergic Reactions: (Describe Symptoms) _____
Food Allergies (Specify): _____
Drugs: (e.g. penicillin) _____
Immunizations and date of last booster: Measles: _____ Tetanus _____ Rubella: _____
Polio: _____ Hepatitis B _____

Activities Restrictions: _____

Please specify any other special needs: _____

HEALTH SCREENING – This section to be completed by Camp Nurse at Campsite.

OBSERVATION & DISCUSSION: (examination necessary only for a "YES" answer)

Sore Throat: _____ Ear Ache: _____ Rash: _____ Itchy Scalp/Lice: _____ Athlete's Foot: _____

Recent exposure to measles/mumps/chicken pox: _____

Review of medication(s) brought to camp: YES – NONE Logged on routine Drug Form: YES

Ask: "Are you generally healthy now?" YES – NO

Comments: _____

Camp Nurse: _____ Date/Time: _____