Medical Release Form

Without this completed form your child will not be allowed to participate in any camping event.

Last Name: _____
First Name: _____
Camp Name: _____
Camp Week: ____

For office use only

Personal Information

Name of camper: (Last) _____ (First) _____ (MI) _____
Home Phone _____ D.O.B._____ Age: _____ Gender: _____
Parent/Guardian (Last) _____ (First) _____
Address: _____ City/State: _____ Zip: _____
1st Emergency Contact: _____ Ph #:_____
2nd Emergency Contact: _____ Ph #:_____
Physician Name: _____ Ph #:_____
Is the participant covered by family medical hospital insurance? YES NO
If yes, please indicate carrier _____ Policy or Group #:_____
******Please provide a copy of the front and back of the health insurance card and attach to this form.***

Health History

Date of last Tetanus shot: _____ Are immunizations current? _____
If No, which one(s) are not current? _____ Able to take Tylenol or Advil: YES NO
Are you currently on any medication? Please specify: _____
Please list Medications that you are bringing to camp: (All medications must be with the Nurse)
Medication_____Dosage_____x Daily _____Time_____
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Prescribing Physician (s) _____
Does camper have any allergic reactions to?
Bee Stings_____Poison Ivy/Oak _____Drugs_____Foods_____
Please describe any reactions_____
_____
Has camper had any illness, injuries or surgeries? _____
_____
Any special restrictions or considerations while at camp? _____
_____
Has camper had a recent exposure to a contagious or infectious disease? _____
Any concerns we should be aware of, such as health habits, health conditions, menstruation, recent loss or trauma?

THIS BOX MUST INCLUDE THE SIGNATURE OF A LICENSED PHYSICIAN OR CERTIFIED NURSE PRACTITIONER.

I have examined the above camp applicant within the past 6 months and in my opinion, this camper's health is stable enough to participate in an active camp program.
Please Print or Stamp Physician's Name:_____
Licensed Physician's Signature: _____ Phone (____) _____
Date of Form Completion: _____
Form Completed by* _____
*Initial if completed by nurse or physician's assistant. Must be signed within the 6 months prior to the beginning of the camp season.

IMPORTANT: This section must be completed for participation in camp activities.

Parent/Guardian Authorization: This health history is correct and complete as far as I know. The person herein described has permission to engage in all camp activities except as noted. I hereby give permission to the camp's health care provider to provide routine health care; to administer medication; to order x-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician or dentist selected by the camp to secure and administer treatment, including hospitalization, for the person named above. I affirm that the camp, its staff and volunteers are held harmless from any liability claims, judgments, and costs incurred during my/my child's stay at the facility or involvement in the camp experience. This completed form may be photocopied for trips out of camp.

Signature of Parent/Guardian or adult camper: _____
Printed name: _____ Date: _____

I also understand and agree to abide by any restrictions placed on my participation in camp activities.
Signature of camper: _____ Date: _____