

Medical Release Form

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

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 _____
Medication _____	Dosage _____	x Daily _____	Time _____
Medication _____	Dosage _____	x Daily _____	Time _____
Medication _____	Dosage _____	x Daily _____	Time _____

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: _____

Last Name: _____

First Name: _____

Camp Name: _____

Camp Week: _____

For office use only

