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_____
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 12 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 12 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: _____