

HEALTH & RELEASE FORM FOR CAMPERS AND STAFF
(YOU WILL NOT BE ADMITTED TO CAMP WITHOUT THIS AND OTHER LISTED MEDICAL FORMS.
REQUIRES PHYSICIAN'S SIGNATURE.)

Day Camps – Only this form is required

Overnight, primitive, and travel camps: A physical exam, performed within the last 2 years, is required to be attached to this form.

Camp: _____ Camp Location: _____ Camp Dates: _____

Camper/Staff Name: _____ Sex: _____ Age: _____ Height: _____ Weight: _____

Address: _____
Number and Street (and Apartment) City State Zip Code

Home Tel. #: _____

Parent/Guardian: _____ Tel. # (H): _____ Tel. # (W): _____

Emergency Contact: Name: _____ Tel. #: _____

Location if traveling during camp: _____ Tel. #: _____

HEALTH HISTORY

Physical Restrictions: _____

Medications: A separate Prescription Medication Record Form must be completed for each medication. _____

Medical History a/o Medical Condition(s) which would require special attention: _____

The camp health staff may administer the following over-the-counter medications: Tylenol® or generic Advil® or generic Neither
 The camper or staff member may self-administer the following: Inhaler Epi-pen Neither

HEALTH INSURANCE

Carrier: _____ Policy Number: _____

Policy Holder: _____ Holder's DOB: _____

I hereby certify that the named camper/staff is physically able to participate in the Sports Camp and that I know of no restrictions, physical impairments, or any other condition, other than noted above, which would limit, in any manner, his or her participation in this program.

I hereby give permission for the camp health staff to dispense the prescription medications listed above. I hereby give permission for the named camper/staff to receive emergency medical or surgical treatment and hospitalization if necessary. I understand that every attempt will be made to contact me, or the emergency contact named above, before taking this action. I UNDERSTAND THAT THERE IS RISK OF INJURY TO THE NAMED CAMPER/STAFF AS A RESULT OF CAMP ACTIVITIES, AND KNOWINGLY AND VOLUNTARILY ASSUME ALL RISK OF SUCH INJURY. I will be financially responsible for any medical attention needed during camp or resulting from an injury received at camp. My medical insurance shall be the insurance coverage for any medical treatment.

Signature of Parent or Guardian (or staff member, if over 18)

Date Signed

HEALTH RECORD

| <u>Immunizations</u> | <u>Dates Administered</u> | | |
|---|----------------------------------|-------|-------|
| MMR Vaccine (1 MMR, 1 additional Measles) | _____ | _____ | _____ |
| Measles | _____ | _____ | _____ |
| Mumps | _____ | _____ | _____ |
| Rubella | _____ | _____ | _____ |
| Polio (3 doses) | _____ | _____ | _____ |
| Diphtheria/Tetanus/Pertussis (4 doses) | _____ | _____ | _____ |
| Hepatitis B (3 doses) | _____ | _____ | _____ |

Medical problems, restrictions, limitations, etc. _____

Physician's Name: _____ License # and State: _____

Address: _____

Physician's Signature

Date Signed