HEALTH FORM 2024

Session _____

Due BEFORE MAY 15, 2024

The information requested below will enable the director and staff to understand and serve your child's needs while at camp and will facilitate any medical attention required due to illness or injury. It is therefore of vital importance that this statement be completed and signed by you and your physician. PLEASE BE AS COMPLETE AND HONEST, FOR THE BENEFIT OF YOUR CHILD.

Child's Name _____ Birth Date_____ Age_____

Address _____
City, State, Zip

Parent/Guardian 1 Name _____Work Phone (____) _____Cell(____)_____

Parent/Guardian 2 Name _____Work Phone (____) _____Cell(____)_____

Place of Employment Parent 1_____ Parent 2 _____

Name and telephone number, we should call in an emergency if we could not reach either parent:

Name _____

Phone (____) _____

TO BE COMPLETED BY PHYSICIAN

Date of last examination by physician _____

Physician's Name _____ Phone (_____) _____
Address

_____

Height _____ Weight _____ General Health: _____ very good _____good _____fair _____poor

Are all immunizations and boosters current? _____ Yes _____ No (if no, please specify below)

_____

Restrictions on activities: None _____ Sports _____ Swimming _____ Other _____
(Please Specify)

_____

Restrictions on diet

_____

Allergies: (Please List)

_____

_____

Are there any health conditions of which the CK staff should be aware? **(Examples: Diabetes, epilepsy, chronic sore throats or stomach trouble, ADHD, Depression, Anxiety, Autism, School Problems and or suspension from school, etc.)**
_____Yes _____No (If yes, provide details below)

_____

_____

_____

_____

☒ ***Physician's Signature*** _____ ***Date*** _____

☒ ***Parent's Signature*** ***Date***

TO BE COMPLETED BY PARENT

Note: Signature REQUIRED in TWO places BELOW for acceptance of application.

Child's Name _____

Please provide any information that would help the College for Kids staff better understand and relate to your child: **(Depression, anxiety… If your child takes a medication during the school year but not during CK, please let us know. Examples: ADHD, allergy, etc.)**

_____

_____

_____

_____

PROOF OF INSURANCE (mandatory for acceptance to program)

Name of Insurance Company _____ Policy # _____

Name of policy holder _____

Policy holder's social security # _____ (*If needed for use of the policy*.)

PERMIT AND RELEASE

_____ (my son/daughter) has my/our permission to participate in classes, activities, and field trips with College for Kids Faculty and Staff. I/we also grant permission for College for Kids or its designate to photograph, record, video tape my child; or use verbal or written material from my child during College for Kids activities and to use those materials for promotional or other purposes chosen by College for Kids Board of Directors. I/we authorize and constitute the College for Kids staff to act as my agent in obtaining medical or dental attention for my son/daughter by a licensed physician/dentist and/or hospital if illness or injury occurs while he/she is at camp. I/we also grant permission for medical personnel to obtain any information necessary for effective medical treatment of my/our son/daughter. I/we further agree (i) to indemnify and hold harmless the College for Kids, A Summer Exploration, Inc. director, staff, College for Kids Advisory Council and Board of Directors, cooperating sponsors, and Columbia College, and (ii) to forever refrain and desist from instituting or asserting any claim, demand, actions or suit for injuries or damage resulting from any accident or illness that might occur to my/our son/daughter while attending College for Kids, A Summer Exploration, Inc.

☒ ***Parent/Guardian Signature*: _____ *Date* _____**

Signature REQUIRED ABOVE for Acceptance of Application

MEDICATION INSTRUCTIONS AND AUTHORIZATION

1. **Prescription Medications must be in the original container from the pharmacy.** Indicate dosage and schedule below. If your child is currently taking medication, please call CK in advance to ensure proper procedures are followed.

Name of Medication

_____

Dosage and schedule

_____

Additional instructions regarding prescription medication

_____

2. **Non- Prescription over –the-counter medication** (Such as Tylenol, Pepto-Bismol, etc.) To be administered as needed per dosage directions for child's age and weight with **SIGNATURE below.**

_____

PLEASE NOTE: This form MUST be signed BELOW to ensure proper medical attention during camp. I/we hereby authorize the staff of College for Kids to administer general first aid treatment, non-prescription medications, emergency medical help and prescription medications as per the above instructions, to my/our son/daughter while he/she is at camp.

☒ ***Parent/Guardian Signature: _____ Date _____***

Signature REQUIRED for Acceptance of Application

ALL MEDICATIONS MUST BE IN THE ORIGINAL BOTTLE WITH THE NAME OF THE MEDICATION AND DOSAGE FROM PHARMACY. ALL MEDICATIONS MUST BE HOUSED WITH THE MEDIC