Medical Release and Health Form

Name ______________________________
Address ______________________________
Birth Date ______________ Age __________ Height __________ Weight ______

CONTACT INFORMATION:

Name of Parent/Guardian ______________________________
Address ______________________________
City ______________ State __________ Zip ________
Home Phone ______________ Work Phone ______________
Cell Phone ______________
Employer ______________ City ______________

Emergency Contact: ______________________________
Relationship ______________ Home Phone ______________
Work Phone ______________ Cell Phone ______________

PHYSICIAN AND INSURANCE INFORMATION:

Physician ______________ Phone ______________
Address ______________________________
City ______________ State __________ Zip ________
Insurance Co. ______________ Phone ______________
Address ______________________________
City ______________ State __________ Zip ________

GENERAL HEALTH HISTORY – (give approximate dates/explanation)

fainting ______________ bed wetting ______________
sleep walking ______________ ear infections ______________
heart trouble ______________ chicken pox ______________
rheumatic fever ______________ ADHD ______________
measles ______________ vomiting ______________
headaches ______________ mumps ______________
epilepsy* ______________ stomachaches ______________
asthma* ______________ bleeding/clotting ______________
allergies* ______________ diabetes ______________
convulsions* ______________ other ______________
(*see below)

Any operation or serious injury within the last two years? ______________
Any chronic or recurring illness or ailment within the last two years? ______________
Any exposure to communicable disease within the last month? ________ If so, which one ________
Any activity restrictions? ________ Explain ______________

IMMUNIZATION RECORD: (If Immunized, Give Date)

Tetanus ________ Diphtheria ________ Polio ________ MMR

IF STUDENT IS ASTHMATIC, please answer the following:

Frequency of attacks ______________ Length of attack ______________
Response to attacks (List Medication) ______________________________

IF STUDENT HAS CONVULSIONS, SEIZURES, OR EPILEPSY, please answer the following:

Circle type(s) of seizures (list medications below): Focal Petit Mal Grand Mal
Frequency of seizures________________________________ Length of seizures ________________________________
What does student do after the seizure? (e.g. sleep, rest, return to activity)

IF STUDENT HAS ALLERGIES, please answer the following:

Allergen(s) ____
Response to allergen(s) - specific reaction ____

IF STUDENT HAS ANY DIETARY CONCERNS, please answer the following:

List food allergies and explain ____
List any additional dietary restrictions or special diet concerns _________________________________
Any special diet must be arranged with the Camp Director two weeks prior to arrival.

HOMESICKNESS:

Has student been away from home before? _______________ If yes, when and for how long? _______________
If the student becomes homesick, circle symptoms: stomachache headache nausea vomiting other

PERMISSION TO ADMINISTER MEDICATIONS

Your child's school is responsible for all health-related incidents while at camp. We suggest that the school does not administer any type of medications, including non-prescription medications, without the written or verbal consent of the parent or guardian. If you would like the school to be able to administer Tylenol or other non-prescription medications, please include those in the authorization. All medications that you send, with the exception of some inhalers, will be locked in our first aid station and administered by an adult from your child's school.

I give my permission for the school teacher in charge to keep and administer the following medications:

Medication ________________________________ Dosage/Frequency ________________________________
Reason ________________________________ Special Instructions ________________________________

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Reason ________________________________ Special Instructions ________________________________

RELEASE OF INFORMATION:

The undersigned, as parent/legal guardian of the child registered, authorizes Luther Glen and its designated leaders to consent to any medical or hospital care to be rendered to said minor upon the advice of a licensed physician. This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California. It is understood that if time and circumstances reasonably permit, Luther Glen will endeavor, but is not required, to communicate with the undersigned prior to such treatment.

The undersigned further agrees that Luther Glen and its designated leaders are not legally or financially liable for any claim arising from any consent given in good faith in connection with such diagnosis or advised treatment. I hereby consent to the release of any and all records of medical treatment or care given to my child from an emergency room or doctor's office to Luther Glen, and I request that a camp Accident Report be filled out.

*I give my permission for my child to participate in all activities, **including Community Dynamics and Swimming, ,** except where noted above.*

I give my permission for the school teacher in charge to keep and administer the above medication

SIGNATURE: ____ **DATE:** ____________________