

# 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 \_\_\_\_\_  
Medication \_\_\_\_\_ Dosage/Frequency \_\_\_\_\_  
Reason \_\_\_\_\_ Special Instructions \_\_\_\_\_  
Medication \_\_\_\_\_ Dosage/ Frequency \_\_\_\_\_  
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: \_\_\_\_\_