HEALTH & RELEASE FORM FOR CAMPERS AND STAFF

(YOU WILL NOT BE ADMITTED TO CAMP WITHOUT THIS AND OTHER LISTED MEDICAL FORMS.)

Day (non-sports) Camps – No Physical Exam is required; parent or guardian may complete bottom portion. Immunization proof required.

Overnight, primitive, sports and travel camps – A physical exam, performed within the 18 Months, is required to be attached to this form, or the bottom of the form completed and signed by an appropriate medical authority. Immunization proof required.

Camp: ____________ Camp Location: ____________ Camp Dates: June 26-August 18, 2023

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. #: ____________

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 Camp and that I know of no restrictions, physical impairments, or any other condition, other than noted below, 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 below. 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 AND EXAMINATION

Immunizations: In accordance with current Centers for Disease Control guidelines. (Attach Immunization Forms)

Allergies? ☐Yes ☐No Explain: ____________

Special Diet? ☐Yes ☐No Explain: ____________

Special Needs? ☐Yes ☐No Explain: ____________

Prescription Meds.? ☐Yes ☐No Explain: ____________

Other Pertinent Medical Information: ____________

I certify that I have physically examined the above named camper, and that the individual ☐Is ☐Is not able to participate in all camp activities. (If "Is not" please explain restrictions:) ____________

Provider's Name: ____________ License # and State: ____________

Provider's Address: ____________

____________ ____________

Medical Provider's Signature *Date Signed*