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:		
Camper/Staff Name:	Sex:	Age:	Height:	Weight:	
Address:					
Number and St	reet (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 of	ver-the-counter medications	: Tylenol ® or ger	neric Advil ® or ge	eneric Neither	
The camper or staff member may self-administer the following:					
HEALTH INSURANCE					
Carrier:		Policy Number:			
Policy Holder:					
•	ically abla to narticipate in th	-		Avoigal impairments or	
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					
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 memb	per, if over 18)	_	Date S	igned	
HEALTH RECORD AND EXAMINATION					
Immunizations: In accordance with current Centers for Disease Control guidelines. (Attach Immunization Forms)					
Allergies? Yes No Explain:	or Disease Control guidelines	s. (Attach immunizatioi	1 Forms)		
Allergies: Tes Tivo Explain.					
Special Diet? Yes No Explain:					
opeda Diet: Tes Two 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 \Boxed 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					
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