

CAMP DISCOVERY MEDICAL RELEASE FORM

The information on this form is not part of the camper or staff acceptance process but is gathered to assist us in identifying appropriate care. Provide complete information so that the staff can be aware of your child's needs. Any changes to this form should be submitted to camp personnel upon participant's arrival in camp.

IMPORTANT THIS BOX MUST BE COMPLETED FOR ATTENDANCE

I, the undersigned, hereby give permission for my child to participate in all activities and assume all risks and hazards incidental to the program. I also hold harmless Camp Discovery, its staff and appointed assistants. I, also understand and agree to abide by any restrictions placed on my participation in camp activities.

Parent/Guardian Authorizations: This health history and any attached forms are correct and complete as far as I know, and the person herein described has permission to engage in all camp activities.

I hereby give permission to Camp Discovery to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes. I give permission to the staff to arrange necessary related transportation for me/my child. In an event that I can not be reached in an emergency, I hereby give permission to the physician selected by the staff to secure and administer treatment, including hospitalization, for the camper named in this form. This completed form may be photocopied.

X _____
Signature of parent/guardian or adult camper/staffer

Printed Name

Date

CAMPERS LEGAL FIRST NAME														

CAMPERS LAST NAME														

GRADE		GENDER			CAMPERS DATE OF BIRTH				
		M	F	DAY	MONTH	YEAR			
					-		-		

HOME ADDRESS														

CITY						

PARENT FIRST NAME														

PARENT LAST NAME														

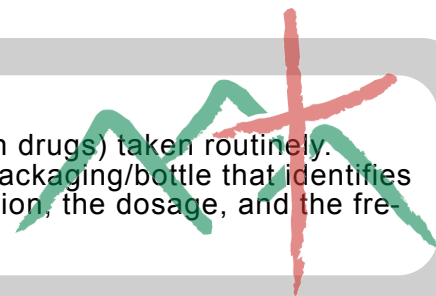
ADDRESS (IF DIFFERENT FROM ABOVE)														

PARENT CELL PHONE						

PARENT EMAIL														

EMERGENCY CONTACT														

EMERGENCY CELL PHONE							RELATIONSHIP							



MEDICATIONS

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

This Person takes **NO MEDICATIONS** on a routine basis

This Person **TAKES MEDICATION** as follows

Med #1:	Dosage:	Specific Times Taken:
Reason for taking:		
Med #2:	Dosage:	Specific Times Taken:
Reason for taking:		

Attach additional pages for more medications

Please identify any medications that this person may **not** take:

ALLERGIES

Camp Discovery does not provide special diets. Allergy producing foods, like peanut butter, will be served at some meals. Campers are expected to be aware of their own food allergies and avoid such food at meals where that food is served.

List all Known Allergies	Describe reaction and management of reaction

SPECIAL NEEDS

Camp Discovery does not have the staff or facilities to properly care for children who have medical, social, behavioral, or psychological needs that require care beyond basic first aid. Children that have needs within this scope should not be permitted to attend camp.

INSURANCE INFORMATION

Is the participant covered by family medical/hospital insurance? Yes No

If so, indicate carrier or plan name _____

Group# _____

Name of insured _____

Relationship to participant _____

Cédula number of policy holder or Insurance ID number _____

HEALTH HISTORY (EXPLAIN "YES" ANSWERS BELOW)



Has/does the participant: Yes/No

- | | |
|--|--|
| <p>1. Had any recent injury, illness or infectious disease? <input type="checkbox"/> <input type="checkbox"/></p> <p>2. Have a chronic or recurring illness/condition?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>3. Ever been hospitalized?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>4. Ever had surgery?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>5. Have frequent headaches?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>6. Ever had a head injury?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>7. Ever been knocked unconscious?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>8. Wear glasses, contacts or protective eye wear?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>9. Ever had frequent ear infections?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>10. Ever passed out during or after exercise?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>11. Ever been dizzy during or after exercise?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>12. Ever had seizures?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>13. Ever had chest pain during or after exercise?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>14. Ever had high blood pressure?..... <input type="checkbox"/> <input type="checkbox"/></p> | <p>15. Ever been diagnosed with a heart murmur?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>16. Ever had back problems?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>17. Ever had problems with joints (knees, ankles)?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>18. Have an orthodontic piece being brought to camp? <input type="checkbox"/> <input type="checkbox"/></p> <p>19. Have and skin problems (itching, rash, acne)?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>20. Have diabetes?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>21. Have asthma?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>22. Had mononucleosis in the past 12 months?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>23. Had problems with diarrhea/constipation?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>24. Had problems with sleepwalking?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>25. If female, have an abnormal menstrual history?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>26. Have a history of bed-wetting?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>27. Ever had an eating disorder?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>28. Ever had emotional difficulties for which professional help was sought?..... <input type="checkbox"/> <input type="checkbox"/></p> |
|--|--|

Please explain "yes" answers, noting the number of questions.

Which of the following has the participant had?

- Measles
 Chicken pox
 German measles
 Mumps
 Hepatitis A
 Hepatitis B
 Hepatitis C

VACCINATION HISTORY

Vaccine	Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP							
TD (Tetanus/Diphtheria)							
Tetanus							
Polio							
MMR							
Haemophilus influenza B							
Hepatitis B							
Veracilla (Chicken Pox)							
TB Mantoux Test	Date of Last Test		Results	<input type="checkbox"/> Positive <input type="checkbox"/> Negative			

DOCTOR INFORMATION

Camper's physician _____ Phone _____

Address _____

Camper's dentist/orthodontist _____ Phone _____

Address _____