MEDICAL INFORMATION AND RELEASE
SUMMER CAMP
MINOR OR ADULT PARTICIPANT

NAME: _____
Last First Middle

ADDRESS: _____
Street City/State Zip

DATE OF BIRTH: ____/_____/_____

HEALTH/ACCIDENT INSURANCE CARRIER: _____

POLICY NO: _____ GROUP #: _____

PERSONAL PHYSICIAN: _____

PHYSICIAN'S ADDRESS: _____

PHYSICIAN'S PHONE #: _____

PAREN, LEGAL GUARDIAN, OR OTHER PERSON WHO HAS LEGAL AUTHORITY TO AUTHORIZE MEDICAL TREATMENT TO PARTICIPATE IN CASE OF EMERGENCY. PLEASE CONTACT:

NAME: _____

ADDRESS: _____
_____

HOME TEL: _____ WORK TEL: _____ ALT TEL: _____

Please list any chronic or acute medical problems (Continue on back if needed: _____

_____

Please explain: _____

_____

List any allergies to food, pollen or medicine: _____

_____

List any medications being taken at present: _____

_____

I ACKNOWLEDGE PARTICIPANTS IMMUNIZATIONS ARE CURRENT: _____ YES _____NO

I or MY CHILD plan to attend a SUMMER CAMP, hereinafter referred to as "CAMP." I fully realize that injury or illness could result from or during MY or MY CHILD's participation in the SUMMER CAMP. In case of accident or illness, I give my permission to receive medical treatment as deemed appropriate. I will assume responsibility for any medical bills.

_____
ADULT PARTICIPANT OR PARENT/LEGAL GUARDIAN SIGNATURE (REQUIRED IF PARTICIPANT IS UNDER AGE 18)

PLEASE PRINT CAMP PARTICIPANT'S NAME: _____

IF MINOR, PLEASE PRINT PARENT'S NAME: _____