

CAMP ALLEN MEDICAL RELEASE FORM

Camp attending: (check one) ___Senior High, ___Junior High, ___Junior I, ___Junior II

CAMPER:

Name: _____
Birth Date: _____ / _____ / _____ Age: _____ Sex: _____Female _____Male
Address: _____
City: _____ State: _____ Zip: _____

CONTACT:

Parent/Guardian: _____
Phone: Day _____ - _____ Night _____ - _____ Cell _____ - _____
Other person in case of emergency: _____
Phone: Day _____ - _____ Night _____ - _____ Cell _____ - _____
Church Attending: _____ City: _____

CAMPERS HEALTH INFORMATION:

Insurance Company: _____ Policy # _____

CAMP ALLEN provides secondary insurance. It will cover whatever the camper's insurance does not cover, up to a certain limit.

Child's Doctor _____ Phone: _____ - _____

Date of last Tetanus shot _____ List all medication you take on a regular basis and/or any you bring to camp (prescription Medications **MUST** have pharmacy label and name of doctor): _____

Special health conditions _____

Physical Limitations (allergies, asthma, diabetes, etc.) and/or special instructions _____

Camper has permission to engage in all camp activities except (list Prohibited activities) _____

PERMISSION SIGNATURE

My signature below indicates my willingness to permit the nurse to administer first-aid and over the counter drugs (aspirin, Tylenol, etc.) as needed to my child. It also indicates in the event I cannot be reached in an emergency, I hereby give permission for the physician selected by Camp Allen Staff to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child named above.

Comments: _____

Signed _____ Date _____