



Participant's Agreement to Abide by Restrictions

I, _____, understand and agree to abide by the restrictions placed on my activities during this program.

Signature: _____ Date: _____
(minor participant or adult participant)

MEDICAL EMERGENCY FORM

Insurance Information

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

If YES, indicate the insurance carrier/plan name: _____

Group #: _____

Insurance company address: _____

Name of policy holder (if other than applicant): _____

Relationship to participant: _____

Social Security number of policy holder or insurance ID number: _____

EMERGENCY RELEASE AGREEMENT

Parent /guardian must sign the emergency release agreement. If for religious reasons you cannot sign this, contact the program director for a legal waiver, which must be signed for attendance.

Permission to Provide Necessary Treatment or Emergency Care:

In the event of an accident or illness that requires emergency medical care, I hereby give permission to the attending (licensed) medical personnel to order such medical attention as may be deemed necessary for the health and safety of me / my child (or the person of whom I am legal guardian). In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the Director to secure and administer treatment, including hospitalization, for the person named above. The medical information above is complete and accurate to the best of my knowledge.

Applicant Name (Please Print): _____

Applicant Signature: _____ Date: _____

Parent/Guardian Name (Please Print): _____



Parent/Guardian Signature: _____ Date: _____

HEALTH HISTORY AND MEDICAL RELEASE FORM

The information on this form is not part of the participant acceptance process. This information is gathered to assist in identifying appropriate care for the participant. All medical information is confidential. This form must be completed by the parent(s)/guardian of minors and by any adult volunteer or program participant. Keep a copy of the completed form for your records. Any changes to this form should be provided to the Program Director prior to the participant's involvement in the residential program. Please make sure that that you provide detailed and accurate information so that the staff members are aware of your/your child's needs.

Applicant's Name (Last, First, Middle): _____

Home Address: _____

Social Security #: _____ Birth Date: _____ Age: _____

Parent / Guardian's Name: _____

Home Language: _____

Parent / Guardian's Daytime Phone: _____ Evening Phone: _____

Please list TWO other emergency contacts:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Does the applicant have physical limitation that will restrict participation in program activities? Yes No

If Yes, explain: _____

Has the applicant been injured and needed medical treatment within the last year? Yes No

If Yes, explain: _____

Is the applicant presently undergoing professional counseling or therapy? Yes No _____

If Yes, explain: _____

Allergies

Allergies to Medication

List all known: _____

Describe reaction and management to the reaction: _____

Allergies to Food

List all known: _____

Describe reaction and management to the reaction: _____



Other Allergies – include stings, hay fever, asthma, animal dander, etc.

List all known: _____

Describe reaction and management to the reaction: _____

Medications

Please list all medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire duration of the program. 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.

Does this participant take medications on a routine basis? Yes No

Will the applicant be taking any prescribed medication during the program? Yes No

If YES please provide the following information: (Attach additional pages for more medications.)

Med #1: _____ Dosage: _____

Specific times taken each day: _____

Reason for taking: _____

Identify any medications taken during the school year that participant does/may not take during the summer:

HEALTH HISTORY AND MEDICAL RELEASE FORM CONTINUED

Does the applicant have any of the following medical conditions? (Check all that apply)

- Asthma Allergies Convulsive Disorders HIV Positive
- Heart Problem Pulmonary Disorders Muscular-Skeletal Disorder Diabetes Mellitus
- Hepatitis Otitis Media Skin Infection Neurological Disorder
- Epilepsy Other issues the medical staff should be aware of? (Please elaborate)

Parent/Guardian Authorization

This health history is correct and complete as far as I know, and the person herein described has permission to engage in program activities excepted as noted.

Signature: _____ Date: _____

Dietary Restrictions

Please remember that this is a camp setting. Food cannot be prepared to order. The facilities may not have a kosher kitchen. _____

Please check all restrictions that apply to this individual.

- Does not eat red meat Does not eat pork Does not eat eggs

DIVERSITY
Memphis
FreeLand

- Does not eat poultry
 - Does not eat seafood
 - Does not eat dairy products
 - Other (If other, please use the space below or separate sheet to explain)
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