



**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: \_\_\_\_\_

**(Must be signed before acceptance)**



## 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. \_\_\_\_\_

\_\_\_\_\_