

## Saint Mary's Summer Camp Health, Consent and Release Form

Information in this document is protected by HIPPA privacy laws and should be handled accordingly

One person per form!

Name: \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex \_\_\_\_ Age \_\_\_\_ Gr. Fall '19 \_\_\_\_  
Last First MI

Parent or Guardian (or spouse) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_

Home Address \_\_\_\_\_ Home Phone ( ) \_\_\_\_\_  
Street Address City State Zip

Second Parent or Guardian Emergency Contact: \_\_\_\_\_

Home Address \_\_\_\_\_ Contact Phone ( ) \_\_\_\_\_  
Street Address City State Zip

If not available in an emergency, notify: Name \_\_\_\_\_

Home Address \_\_\_\_\_ Contact Phone ( ) \_\_\_\_\_  
Street Address City State Zip

### Recommendations and Restrictions While At Camp

Any Treatment to be continued at camp \_\_\_\_\_

Any medication to be administered at camp (specific dosages) \_\_\_\_\_

Any medically prescribed meal plan or dietary restrictions \_\_\_\_\_

Any Allergies (Food, drugs, plants, insects) \_\_\_\_\_

Additional health information/activities to be limited \_\_\_\_\_

Operations or serious injuries (Dates) \_\_\_\_\_

Chronic or recurring illness or medical condition \_\_\_\_\_

Dietary Restrictions \_\_\_\_\_

Current Medications (send in prescription bottles) \_\_\_\_\_

Other Diseases \_\_\_\_\_

Name of Family Physician \_\_\_\_\_

Name of Dentist/orthodontist \_\_\_\_\_

Special Health and behavioral considerations \_\_\_\_\_

Health History: (give approx dates)	
<input type="checkbox"/> Frequent Ear Infections <input type="checkbox"/> Heart Defect/Disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Bleeding/Clotting Disorder <input type="checkbox"/> Hypertension <input type="checkbox"/> Mononucleosis <input type="checkbox"/> Convulsions <input type="checkbox"/> Epilepsy	<input type="checkbox"/> Chicken Pox <input type="checkbox"/> Measles <input type="checkbox"/> German Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Hepatitis A <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hepatitis C
Allergies (Date not needed)	
<input type="checkbox"/> Hay Fever <input type="checkbox"/> Ivy Poisoning, etc <input type="checkbox"/> Insect Stings <input type="checkbox"/> Other (Specify) _____ <input type="checkbox"/> Penicillin <input type="checkbox"/> Other Drugs <input type="checkbox"/> Aasthma	

### Authorization for treatment

This health history is correct as far as I know, and the person herein described has permission to engage in all camp activities except as noted. I hereby give permission to the medical personnel selected by the camp director to order x-rays, routine tests, treatment; to maintain and/or release any medical records necessary for insurance purposes as outlined under the HIPAA regulations; and to provide or arrange necessary related transportation for me or my child. In an emergency, I hereby give permission and authorize the physician selected by Saint Mary's Summer Camp to secure or administer emergency medical treatment, including hospitalization and any other emergency medical procedures which may be needed for the person named above. I authorize the physician or dentist to call in any necessary consultants in his/her discretion. It is understood that this consent is given in advance of any specific diagnosis or treatment being required, but is given to encourage those persons who have temporary custody of the minor, and said physician or dentist to exercise their best judgment as to the requirements of such diagnosis or medical, dental or surgical treatment.

I agree to remain fully liable and responsible for the payment of any such hospital, doctor, ambulance, dental or medical fees. I further agree that in giving this permission and authorization, St. Mary's does not assume any responsibility or liability for the payment of such hospital, doctor, ambulance, dental or medical fees which may be incurred.

Signature of parent or guardian or minor/adult volunteer \_\_\_\_\_ Date \_\_\_\_\_

Persons authorized to pick up child other than parent or guardian \_\_\_\_\_

This form **Must** accompany up-to-date immunization/vaccine record from Doctor's office. Our health/consent and release form does not require a doctor's signature.