

# City Kids Camp/USA Camp Group

## MEDICAL AND LIABILITY RELEASE

Organization: Children's Earth Foundation

Camp Session: June 23<sup>rd</sup> until June 27<sup>th</sup>

NAME \_\_\_\_\_ AGE \_\_\_\_\_ M/F \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

*Print Last Name First Name*

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE (\_\_\_\_\_) \_\_\_\_\_ CELL PH. (\_\_\_\_\_) \_\_\_\_\_ EMAIL \_\_\_\_\_

IN EMERGENCY NOTIFY \_\_\_\_\_ PHONE (\_\_\_\_\_) \_\_\_\_\_ FAMILY DOCTOR \_\_\_\_\_

\_\_\_\_\_ PHONE (\_\_\_\_\_) \_\_\_\_\_ **HEALTH HISTORY:**

\_\_\_\_\_ Drug Allergies \_\_\_\_\_ Heart Condition \_\_\_\_\_ Behavior/Nervous Disorder

\_\_\_\_\_ Food Allergies/Restrictions \_\_\_\_\_ Asthma \_\_\_\_\_ Physical Handicap

\_\_\_\_\_ Environmental Allergies \_\_\_\_\_ Seizure Disorder \_\_\_\_\_ Stomach Problems

\_\_\_\_\_ Insect Stings \_\_\_\_\_ Diabetes \_\_\_\_\_ Recent Injury/Illness

If any of the above are checked, please give details (i.e., include normal treatment of allergic reactions) \_\_\_\_\_

Name, dosage, and frequency of any medications that must be taken regularly, or as needed: \_\_\_\_\_

swimming restrictions: Yes \_\_\_ No \_\_\_ Any activity restrictions: Yes \_\_\_ No \_\_\_ What restrictions? \_\_\_\_\_

Date of last Immunization: Tetanus/Dtap/DT/Td \_\_\_\_\_, Polio \_\_\_\_\_, MMR \_\_\_\_\_, TB Date and result \_\_\_\_\_, Chicken Pox Vaccine \_\_\_\_\_ Flu Vaccine \_\_\_\_\_  
(Varicella)

☐ Has had no immunizations (declined) \_\_\_\_\_

If you have medical insurance, your carrier will be billed for medical charges in case of illness or injury while your child is in camp. Do you have Health Insurance? Yes \_\_\_ No \_\_\_

Name of Insurance Company \_\_\_\_\_

Insurance Company Address \_\_\_\_\_ Policy Number \_\_\_\_\_

### MEDICAL RELEASE:

*In the event I cannot be reached in an emergency during the camp dates as shown on this form, I hereby give my permission to the physician or dentist selected by City Kids Camp/USA Camp Group to hospitalize, to secure proper treatment and/or order an injection, anesthesia, or surgery for my child as deemed necessary. I also authorize the nurse/EMT on duty at camp to administer medical aid as required for illness or injury under a physician's orders. The signature of the parent or guardian below is intended to serve as a medical release. This form may be copied and given to the counselor if there is information pertinent to the care of your child. If there is a reason that you wish this information to stay confidential, please contact our Director, Hector Corona at 312-217-1258 or email at hc@educate-trade-create.com.*

Health Screen Complete: Yes \_\_\_ No \_\_\_ Medication Administration Record Complete: Yes \_\_\_ No \_\_\_

Parent or guardian's signature \_\_\_\_\_ Relationship to child \_\_\_\_\_

(You may sign your own Release if you are 18 or older)

Print Name \_\_\_\_\_ Spouse's Name \_\_\_\_\_ Date \_\_\_\_\_

Parent or guardian's signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_ Relationship to child \_\_\_\_\_