## HEALTH & RELEASE FORM FOR CAMPERS AND STAFF

## (CHILDREN WILL NOT BE ADMITTED TO CAMP WITHOUT THIS FORM.) NOTE: PARENTS COMPLETE AND SIGN TOP HALF. PHYSICIAN COMPLETES AND SIGNS BOTTOM HALF

Location if traveling during camp:       Tel. #:         HEALTH HISTORY/TRANSPORTATION         Physical Restrictions:	Camp: Williamstown Youth Center	Camp Location:	66 School St., Williamstown	Camp Dates:	June 29, 2015 – August 21, 2015
Number and Street (and Apartment)       City       State       Zip Code         Home Tel. #:		Sex:	Age:	Height:	Weight:
Parent/Guardian:       Tel. # (H):       Tel. # (W):         Emergency Contact:       Name:       Tel. #:         Location if traveling during camp:       Tel. #:       Tel. #:         Physical Restrictions:       HEALTH HISTORY/TRANSPORTATION         Physical Restrictions:       Medications: A separate Prescription Medication Record Form must be completed for each medication.         Medical History alo Medical Condition(s) which would require special attention:		(and Apartment)	City	State	Zip Code
Emergency Contact:       Name:       Tel. #:	Home Tel. #:				
Emergency Contact:       Name:       Tel. #:	Parent/Guardian:	Tel. # (H):		Tel. # (W):	
Location if traveling during camp:       Tel. #:         Physical Restrictions:       HEALTH HISTORY/TRANSPORTATION         Medications: A separate Prescription Medication Record Form must be completed for each medication.					
Physical Restrictions:				Tel. #:	
Medical History a/o Medical Condition(s) which would require special attention:		EALTH HISTORY/TR	ANSPORTATION		
The camp health staff may administer the following over-the-counter medications:Tylenol ® or genericAdvil ® or genericAvil P camper or staff member may self-administer the following:InhalerEpi-penNeitherTransportation: I acknowledge that some activities require transportation by bus, van, or car and provide permission for my child(ren) to use transportation provided by the Williamstown Youth CenterYes orNoNoNo	Medications: A separate Prescription Medication Record	d Form must be comp	pleted for each medication	n	
The camper or staff member may self-administer the following:InhalerEpi-penNeither	Medical History a/o Medical Condition(s) which would re	quire special attention	n:		
Carrier: Policy Number:	The camper or staff member may self-administer the foll Transportation: I acknowledge that some activities requi	owing: Inhaler re transportation by b	Epi-pen Neith us, van, or car and provi	er	—
Carrier: Policy Number:		HEALTH INSU	JRANCE		
Policy Holder:	Carrier:				
I hereby certify that the named camper/staff is physically able to participate in the Sports Camp and that I know of no restrictions, physical impairments, or any other condition, other than noted above, which would limit, in any manner, his or her participation in this program. I hereby give permission for the camp health staff to dispense the prescription medications listed above. I hereby give permission for the mamed camper/staff to receive emergency medical or surgical treatment and hospitalization if necessary. I understand that every attempt will be made to contact me, or the emergency contact named above, before taking this action. I UNDERSTAND THAT THERE IS RISK OF INJURY TO THE NAMED CAMPER/STAFF AS A RESULT OF CAMP ACTIVITIES, AND KNOWINGLY AND VOLUNTARILY ASSUME ALL RISK OF SUCH INJURY. I will be financially responsible for any medical attention needed during camp or resulting from an injury received at camp. My medical insurance shall be the insurance coverage for any medical treatment. I also understand that it is my responsibility to apply sunscreen to my child(ren) before camp each day.  Signature of Parent or Guardian (or staff member, if over 18)  Measles Mumps Rubella Polio (3 doses) Diphtheria/Tetanus/Pertussis (4 doses) Hepatitis B (3 doses) Center of the doses of the dose of the doses of the dose of the dose of the doses of the dose of the dose of the doses of the dose o	Policy Holder:				
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Immunizations       Dates Administered         MMR Vaccine (1 MMR, 1 additional Measles)	named camper/staff to receive emergency medical of will be made to contact me, or the emergency conta INJURY TO THE NAMED CAMPER/STAFF AS A RES OF SUCH INJURY. I will be financially responsible camp. My medical insurance shall be the insurance	or surgical treatmen act named above, be ULT OF CAMP ACTI for any medical atte e coverage for any f	t and hospitalization if fore taking this action VITIES, AND KNOWING ention needed during o	necessary. I understar . I UNDERSTAND THA GLY AND VOLUNTARIL camp or resulting from	nd that every attempt T THERE IS RISK OF Y ASSUME ALL RISK an injury received at
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MMR Vaccine (1 MMR, 1 additional Measles)		HEALTH RE	CORD		
MMR Vaccine (1 MMR, 1 additional Measles)	Immunizations		Dates Ad	ministered	
Measles       Image: Construction of the sector of the secto					
Mumps					
Rubella					
Polio (3 doses)					
Diphtheria/Tetanus/Pertussis (4 doses)					
Hepatitis B (3 doses)					
Medical problems, restrictions, limitations, etc. Physician's Name: License # and State:					
Physician's Name: License # and State:	· · · · · <u>-</u>		•		
Address:			License # and State:		
	Address:				

Physician's Signature