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 REGARDING IMMUNIZATIONS OR PARENT SUBMITS IMMUNIZATION RECORD

Camp: Williamstown Youth Center Camp Location: **66 School St., Williamstown** Camp Dates: June 29, 2015 – August 21, 2015

Camper/Staff Name: _____ Sex: _____ Age: _____ Height: _____ Weight: _____

Address: _____

Number and Street (and Apartment) *City* *State* *Zip Code*

Home Tel. #: _____

Parent/Guardian: _____ Tel. # (H): _____ Tel. # (W): _____

Emergency Contact: Name: _____ Tel. #: _____

Location if traveling during camp: _____ Tel. #: _____

HEALTH HISTORY/TRANSPORTATION

Physical Restrictions: _____

Medications: A separate Prescription Medication Record Form must be completed for each medication. _____

Medical History a/o Medical Condition(s) which would require special attention: _____

The camp health staff may administer the following over-the-counter medications: ☐Tylenol ® or generic ☐Advil ® or generic ☐Neither

The camper or staff member may self-administer the following: ☐Inhaler ☐Epi-pen ☐Neither

Transportation: 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 Center. ___Yes or ___No

HEALTH INSURANCE

Carrier: _____ Policy Number: _____

Policy Holder: _____ Holder's DOB: _____

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 named 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) *Date Signed*

HEALTH RECORD

Immunizations	Dates Administered			
MMR Vaccine (1 MMR, 1 additional Measles)				
Measles				
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: _____

Address: _____

_____ _____

Physician's Signature *Date Signed*