Minor Medical Release Form

Please include a photocopy (front and back) of any medical/card. This is necessary for emergency medical treatment and if prescription medication is lost or damaged.

Insurance Information

Minor Full Name: ____
First MI Last

Birthday: ____/____/______ Social Security Number: ______-_______-______ Gender: *M* *F*

Parent or Guardian Name: ____
First MI Last

Relationship to Minor: ____

Home Phone: ( ) _____ - _______ Cell Phone: ( ) _____ - _______

Address: ____

City: ________________________ State: __________ Zip Code: ______________

Email: ____

Family Physician: ______________________________ Phone: ( ) _____ - _______

Insurance Company: ________________________ Policy Number: __________________

Group Number:______________________________ Phone: ( ) _______ - _______

Insured Name: ______________________________ Birthday: _____/_____/_____
First MI Last

Social Security Number: ______-_______-______ Preferred Pharmacy: ________________________

If not available in an emergency, please contact: (please provide at least one emergency contact)

Name: ______________________________________ Phone: ( ) _____ - _______

Name: ______________________________________ Phone: ( ) _____ - _______

Name: ______________________________________ Phone: ( ) _____ - _______

Minor Medical History

Minor's Current Health Condition: *Excellent* *Good* *Poor* Contact Lenses: *Yes* *No*

List all medication sent with camper **(note: all prescription medications must be in the original bottle with the minor's name typed on the label in order for the nurse to distribute medications)**

Name of Medication	Dosage	Time(s) of Day	Medical Reason

***I authorize the medications listed above, to be dispensed by Camp of the Hills staff members.**

Minor has ever had a history of: Please check any and all that apply

____ Asthma
____ Broken Bones
____ Congenital defect
____ Seizures
____ Hepatitis
____ Rheumatic Fever
____ Diabetes
____ Emotional Problems
____ Nervous Stomach
____ Operation: (please Specify)
____
____

Please explain any special medical needs, please give details (i.e. asthma, diet restrictions, sunburns easily, bed wetter, sleep walker, menstrual difficulties, hearing impairment, etc.):

____

____

Please explain all allergies and reactions (i.e. bug stings, food allergies, allergic reactions to any medications, etc.): ____

____

Any problems requiring special attention (behavioral issues, mental disorders, developmental delays, severe emotional trauma, etc.):

____

____

Please Furnish the name of school camper attends:

Minor camper attends ____and is current on all required immunizations.

_____My child is not enrolled in a school system. *If not enrolled in school, please attach a copy of current immunization record to this form.*

The following are typical activities at Camp of the Hills. Please check any activity that your child cannot participate in for medical reasons, and please provide an explanation.

Activity	**My child may not participate in this activity because:**
Hiking	
Water Activities	
Ropes Course	
Competitive Sports	
Strenuous Activity	

Parental Authorization

To the best of my knowledge, all information provided about the named person is correct, accurate, and complete. Permission is granted to participate in camp activities, including the Ropes Course, except as indicated. Permission is granted for Camp of the Hills to photograph my child and use these photograph, slideshows, promotional items, etc. in order to promote Camp of the Hills and the program they facilitate.

Permission is granted for Camp personnel to administer common, non-emergency first aid and medical treatment, along with over the counter medications kept in stock in the infirmary.

Realizing the nature of serious emergencies, and understanding that I may not be able to be reached at such times (although every effort will be made to do so) I give my permission that medical measure may be instituted without delay as dictated by the judgment of the physician selected by Camp of the Hills.

I understand that I will be contacted as soon as possible, in the rare case that an emergency situation arises. If I choose, my family physician and the Camp physician in charge can consult to insure that my child receives the best medical attention available.

Parent/Guardian Signature: ____ Date: _____________
Required if dependent is under the age of 18

Minor Signature: ____ Date: _____________
Required if dependent is 18 or older

*Note: It is not necessary to have an examination by a physician if the camper is enrolled in a public school and has met Texas requirements for school immunizations. Please be sure to attach a copy of the camper's insurance card in case of an emergency.

Any Additional Comments: