Medical Release Form

Camp Shalom, Inc.

Dates of Camp Attendance:______________

Mail to: ***Camp Shalom; 2136 Brady St.; Davenport, IA 52803***

Personal Information

Name (printed) ____Birth Date ______Age at Camp_________

Home Address ____
Street Address City State Zip

Social Security Number of Camper ___________________________________Gender: ❑ Male ❑ Female

Custodial Parent/Guardian:_ _______________________________________Phone__________________________

Home Adress____
(if different than above) Street Address City State Zip

Business Address____Phone_________________________

Second Parent or Guardian or Emergency Contact:

Name____Phone_________________________

Home Address____
(if different than above) Street Address City State Zip

Business Addess____
Street Address City State Zip

If not available in an emergency

Name ____

Relationship____Phone_________________________

Address ____
Street Address City State Zip

Names of persons other than parents/guardians to whom child may be released____________________________

Names of persons to whom the child *may not* be released____

Insurance Information

Is the camper covered by insurance? ❑ *Yes* ❑ *No*

Insurance Company____

Primary Policy Holder_____________________________________ Policy Number_____________________________

Physician's Name____ Phone_____________________________________

Dentist or Orthodontist____________________________________ Phone_____________________________________

Important : Parent/Guardian signature required.

I give consent for my child to leave the camp property in a camp vehicle for swimming, canoeing or other field trips.
❑ *Yes* ❑ *No*

I give my consent to let my child be photographed for use by the camp for promotional material ❑ *Yes* ❑ *No*

Parent Guardian Authorizations: This health history is correct and complete as far as you know. The person herein described has permission to engage in all camp activities except as noted.

I hereby give permission to the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests.

I agree to the release of any records necessary for insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child.

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

Signature of parent/guardian or adult camper/staffer____

Printed Name____ Date_______________

I also understand and agree to abide by any restrictions placed on me/ or my child's participation in camp activities.

Signature of parent/guardian or

adult camper/staffer____ Date_______________

Health History

The following information must be filled in by the parent/guardian, or adult camper or staff member. The intent of this information is to provide camp health care personnel the background to provide appropriate care. Keep a copy of the completed form for your records. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp. Provide complete information so that the camp can be aware of your needs.

This participant has or had:

____ pneumonia	____ eating disorder	____ rupture/hernia	____ chicken pox
____ stomach ulcer	____ kidney disorder	____ ear infection	____ measles
____ tonsillitis	____ diabetes	____ rheumatic fever	____ asthma
____ epilepsy	____ Scarlet fever	____ bronchitis	____ heart disorder
____ migraines	____ hepatitis	____ mononucleosis	____ other:____________________

Please explain any "yes" answers, year of illness, frequency and treatment:______________________________

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Date of last tetanus injection_______________

Date of last physical examination_______________ Height_________ Weight_________

General State of Health____

____

Name of Family Physician_____________________________________ Phone__________________

Address____

Name of Family Dentist/Othodontist_______________________________ Phone__________________

Address____

Allergies – List all known. | Describe reaction and management of the reaction.

Medication Allergies

______________________________ ____

______________________________ ____

______________________________ ____

______________________________ ____

Food Allergies

______________________________ ____

______________________________ ____

______________________________ ____

______________________________ ____

Other Allergies

______________________________ ____

______________________________ ____

______________________________ ____

______________________________ ____

Medications Being Taken – please list ALL medications taken routinely.

❑ This person takes NO medications on a routinely basis.

❑ This person takes medications as follows:

Med #1____________________________________Dosage__________Specific times taken each day____________

Reasons for taking____

Med #2____________________________________Dosage__________Specific times taken each day____________

Reasons for taking____

Med #3____________________________________ Dosage__________ Specific times taken each day____________

Reasons for taking____

Attach additional pages of information, if necessary, regarding medication.

Are there any non-prescription medications you do not want your child to be given? ______________________________

____

Females Only: Has the camper menstruated?_________ If not, has she been told about it?____________________

If so, any special considerations?____

For Office Use Only

To be completed by the camp nurse upon arrival at camp

Scalp____ Body____

Feet____ Throat____

Recent exposure to communicable disease? ____

Did child bring medication?___________

Name of Medication Dosage Times Taken

1.____

2.____

3.____

4.____

Can your child have Tylenol or Ibuprofen for disease?_________ Antacids for stomach?___________________

Any limitations to activity or diet?____

Signature of Nurse____ **Date**_____________________

Do you have any personal information or concerns that would help us better serve your child? ____ Yes ____ No

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PLEASE RETURN TO:
Camp Shalom, INC
2136 Brady St.
Davenport, IA 52803