

# Medical Release Form for Winter Camp 2012

**Please be sure to include a copy of your medical insurance card, THANK YOU!**

Student Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Weight: \_\_\_\_\_

Do You Have Medical Insurance? Yes \_\_\_\_\_ No \_\_\_\_\_

If So, Who is Your Insurance Provider? Name: \_\_\_\_\_

Insurance Policy Number: \_\_\_\_\_ Child's Physician: \_\_\_\_\_

Physician's Phone Number: \_\_\_\_\_ Preferred Hospital: \_\_\_\_\_

Medical History: \_\_\_\_\_

## Check if minor is subject to ANY of the following:

- |   |                                     |   |                                    |
|---|-------------------------------------|---|------------------------------------|
| <input type="checkbox"/> Convulsions    | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Colds          |                                    |
| <input type="checkbox"/> Sore Throats   | <input type="checkbox"/> Fainting   | <input type="checkbox"/> Asthma         |                                    |
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Allergies  | <input type="checkbox"/> Stomach Upsets | <input type="checkbox"/> Headaches |

Date of Last Tetanus Shot: \_\_\_\_\_

## Allergic Reactions:

Aspirin \_\_\_\_\_ Bee Stings \_\_\_\_\_

Penicillin \_\_\_\_\_ Specific Foods \_\_\_\_\_

Other allergies/comments pertinent to child's health: \_\_\_\_\_

**Any activity restrictions?**  Yes  No (If yes, please explain) \_\_\_\_\_

This form authorizes a nurse or adult supervisor designated by Church of the Foothills to provide basic first aid, and to administer over the counter medicines to the above student in the event of injury or illness. In the event of any injury or illness unable to be treated by first aid or over the counter medicines, you will be notified and your child may be taken to a nearby hospital or clinic for treatment, if necessary. **INITIAL:** \_\_\_\_\_

Please list the medicine(s) taken by the student, the time/dosage schedule, and the reason for taking them:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please circle preferences (or provide the medicine(s) you prefer):**

- ➔ Tylenol/Advil for minor pain/fever
- ➔ Robitussin for cough
- ➔ Dimetapp/Sudafed for congestion/cold
- ➔ Benadryl for insect bites or other minor allergic reactions such as hay fever, etc.
- ➔ Caladryl/Cortisone/Benadryl/Polysporin for itching due to possible poison oak or local inflammation
- ➔ Tums/Pepto Bismol for minor stomachache

**I/We, the undersigned, understand that at Cordova Neighborhood Church Rancho Cordova, California, strenuous physical activity, is a regular part of Winter Camp 2012. Specifically, Winter Camp 2011 will include, but not be limited to, the following activities: transportation by bus, play in the snow, running and general play activities.**

To the best of our knowledge, our child, \_\_\_\_\_ is in excellent physical and mental health, and needs no restrictions from strenuous physical activity. If we have any questions regarding our child's health, we understand that it is our obligation to seek professional medical advice and to *inform Cordova Neighborhood of any health problems and restrictions on our child's activities in writing*. We, hereby authorize, Cordova Neighborhood Church Rancho Cordova, California, as agents for the undersigned, to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable or necessary by, and is to be rendered under the general or special supervision and upon the advice of a physician and surgeon licensed under the provisions of the Medical Practice Act of the State of California, or to consent to an x-ray examination, anesthetic, dental or surgical diagnosis or treatment and hospital care to be rendered to the minor by a dentist licensed under the provisions of the Dental Practice Act of the State of California.

It is understood and agreed that this authorization is given in advance of any specific diagnosis, treatment, or hospital care, which the aforementioned physician in the exercise of his best judgment may deem advisable or necessary. I give my full consent for my child to attend any event sponsored by Cordova Neighborhood. I will not hold Cordova Neighborhood, staff, nor advisors responsible nor liable in any way for accidents or injuries that my child may incur while on an outing away from Cordova Neighborhood or at an event on the grounds of the church. I also acknowledge that it is my responsibility to communicate to my child, the need for his/her safe behavior and conduct on all such activities.

**PARENT/GUARDIAN NAME/PLEASE PRINT**

**SIGNATURE & DATE**

**Daytime Phone:** \_\_\_\_\_ **Nighttime Phone:** \_\_\_\_\_

**Cell Phone / Pager:** \_\_\_\_\_

**Please include the name, address, telephone and relationship of two people that can be notified in the event that you cannot be reached:**

**Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Work Phone:** \_\_\_\_\_ **Home Phone** \_\_\_\_\_

**Home Address:** \_\_\_\_\_

**Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Work Phone:** \_\_\_\_\_ **Home Phone** \_\_\_\_\_

**Home Address:** \_\_\_\_\_