MEDICAL INFORMATION AND RELEASE
SUMMER PROGRAMS
MINOR OR ADULT PARTICIPANT

NAME: _____
(LAST) (FIRST) (MIDDLE)

ADDRESS: _____
(STREET) (CITY) (STATE) (ZIP)

DATE OF BIRTH: _____
(MM/DD/YYYY)

HEALTH/ACCIDENT INSURANCE CARRIER: _____

POLICY NO: _____ GROUP NO: _____

PERSONAL PHSYICIAN: _____

PHYSICIAN'S ADDRESS: _____
(STREET) (CITY) (STATE) (ZIP)

PHYSICIAN'S PHONE: (____) _____

PARENT, LEGAL GUARDIAN, OR OTHER PERSON WHO HAS LEGAL AUTHORITY TO AUTHORIZE MEDICAL TREATMENT TO PARTICIPANT IN CASE OF EMERGENCY, PLEASE CONTACT:
NAME: _____ RELATIONSHIP: _____

ADDRESS: _____
(STREET) (CITY) (STATE) (ZIP)

HOME TEL: (____)_____ WORK TEL: (____)_____ CELL: (____)_____

Please list any chronic or acute medical problems (continue on back if needed): _____

_____

_____

Please explain: _____

_____

List any allergies to food, pollen or medicine: _____

_____

List any medications being taken at present: _____

_____

I ACKNOWLEDGE PARTICIPANT'S IMMUNIZATIONS ARE CURRENT: _____YES _____NO

I or *MY CHILD* plan to attend a SUMMER PROGRAM, herinafter referred to as "PROGRAM". I fully realize that injury or illness could result from or during MY or MY CHILD'S participation in the SUMMER PROGRAM. In case of accident or illness, I give my permission to receive medical treatment as deemed appropriate for myself and child. I will assume responsibility for any medical bills for either myself or my child.

_____
ADULT PARTICIPANT OR PARENT/LEGAL GUARDIAN'S SIGNATURE (REQUIRED IF PARTICIPANT IS UNDER AGE 18)

PLEASE PRINT CAMP PARTICIPANT'S NAME: _____
IF MINOR, PLEASE PRINT PARENT'S NAME: _____