



2017 Health History, Emergency Contact, and Release Form

ADDRESS

TELEPHONE NUMBER

FAX NUMBER

WEBSITE

Last Name: [grid] Middle Initial: [grid]

First Name: [grid] Birth Date (MMDDYY): [grid]

Street City/Town State Zip

Male (circle one) Female Identifying Marks: _____

Parent or Guardian Information

Parent or Guardian Address Phone Work Cell Phone Email (Left and Right columns)

Please list at least one emergency contact that, if necessary, could provide transportation home.

Emergency Contact Cell Phone Work (Left and Right columns)

Allergies

Insect Bite Bee Sting Food Seasonal Medications Other (Yes/No, Reaction, Severity)

Please explain/specify any of the above that were answered "Yes" (i.e. type of food allergy, medication associated, etc.)

If medications will be administered at camp for above allergies a "Medication Information Form" must be completed

Physician Information

Name of family physician: Phone:

Insurance Information

Insurance Carrier: Policy Holder Name: Policy/ Group #:

Immunization History: Massachusetts requires a Certificate of Immunization for all campers and staff. You may use the form provided or a copy from your doctor's office. Check if attached

Camper of Staff Name _____

Relevant Past Medical History, General Information, and Restrictions

Does your child (or staff member) have Asthma? **Yes (circle one) No**

*Will your child (or staff member) be bringing an inhaler to camp? **Yes (circle one) No**

Are there any physical, mental, or psychological conditions requiring medication, treatment, or restrictions while at camp?

*Does your child or (staff member) take any prescription or over-the-counter medication at home? **Yes (circle one) No**

Please list any past medical treatment or recent injuries: _____

Describe any specific activities from which your child (or staff member) should be exempted: _____

Any dietary modifications or restrictions? **Yes (circle one) No** Please explain: _____

Does your child have an IEP or 504 plan? **Yes (circle one) No** Please explain: _____

Are there any accommodations or services that we can provide to make the summer as successful as possible? _____

Please share any information that would help Hale Summer Staff best serve your child: _____

***If "Yes" a "Medication Information Form" must be completed**

Authorizations:

Accuracy of Information: This health history is correct so far as I know and the person herein described has permission to engage in all camp activities except as noted.

Photo Release: I authorize Hale, **Partner Camp** and American Camp Association to have my child's (or staff members) photo to appear in camp brochures, videos, on websites or other promotional literature.

Authorization for Treatment: In case of an emergency, I authorize Hale Reservation to administer first aid and to transport my child or (staff member) to the nearest hospital emergency room and to order X-rays; routine tests and treatment; and to release any records necessary for insurance purposes. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director, or his/her designee, to secure and administer treatment, including hospitalization, for the person named above. This form can be photocopied for camp trips.

Authorization for Medications: I authorize the Hale Health Staff and its designees to administer the following medications (on an "as needed" basis unless contraindicated): Acetaminophen (Tylenol), Ibuprofen (Motrin/Advil), Antacid (Tums), Diphenhydramine HCl (Benadryl), and Anti-Itch Creams.

Acknowledgment of Risk and Waiver: I understand and acknowledge my camper (or staff member) may participate in a variety of activities including; swimming, boating, outdoor games, sports, rope course, and other rigorous physical activities. I hereby release and discharge, and agree to indemnify and hold harmless Hale Reservation and its officers, directors, members, agents, employees, volunteers, and any other persons or entities on its behalf, against all claims, demands, and causes of actions whatsoever, either in law or equity, relating to or arising from any participation, medical treatment, recommendation, transportation or administration, or any lack thereof.

Signature of Parent/Guardian of Camper, Staff Member, or Parent/Guardian of Staff Member under 18 years of Age

Signature _____

Date _____