University of Colorado

Medical History and Treatment Permission for Camp Participants

This form is required for all participants; please complete and submit at registration. ***Please Print.***

Camp/Activity Name ____
Attendance Dates _________________ to _________________
Start Date *End Date*

Participant Information:

Name____
First Name *Middle* *Last*

Age ________ Date of Birth _________________ Social Security # __________________________

Home Address ______________________________ _________________ ______ __________
Street Address *City* *State* *Zip*

Father/Guardian Name __________________________________
Address ____
Phone: *Home* (___) __________ *Work* (___) __________ *Cell* (___) __________ *Pager* (___) __________

Mother/Guardian Name __________________________________
Address ____
Phone: *Home* (___) __________ *Work* (___) __________ *Cell* (___) __________ *Pager* (___) __________

Other Contact Person __________________________________
Phone: *Home* (___) __________ *Work* (___) __________ *Cell* (___) __________ *Pager* (___) __________

Family Physician ____ **Phone #:** (__) ______________

Medical History: *(Please use back of this sheet if necessary)* **Date of last tetanus booster**_______________

Allergies: Insect bites/stings *(please list)* ____
Food *(please list)* ____
Drug *(please list)* ____
Other *(please list)* ____

Is the participant under the care of a provider for a medical and/or psychological problem? Yes____ No____
If yes, please explain: ____

Is the participant taking medication prescribed by a health care provider? Yes_____ No_____
*If yes, please explain:*____

Other information we should be aware of ? ____

Payment Information for care and treatment received: Unless your camp is insured through University Risk Management, cash, check, or credit card payment is required at time of service. These charges will not be billed to your insurance company. Please provide credit card information for a card valid during the dates of attendance at the event above.

Visa ____ Master Card ____ Expiration Date __________ Credit Card #__________________________

Name on the Card ______________________________ Signature ______________________________

Parental/Guardian Permission: I give my permission for diagnostic and therapeutic procedures as may be necessary for the above-named participant by any licensed health care facility. I understand that the health care facility will make a reasonable attempt to contact me first, if time and conditions permit. **I agree to be responsible for all charges incurred.**

Name *(Printed)*____________________________ Signature: ________________________________

Date ______________________ Relationship to Participant ______________________________

06-09-04