

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 <u>Super Saturday for Gifted Children</u>
Attendance Dates <u>10/03/09</u> to <u>11/07/09</u>
<i>Start Date</i> <i>End Date</i>

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 additional 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 ? _____

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 _____