MASSACHUSETTS - HEALTH & RELEASE FORM FOR CAMPERS

(YOU WILL NOT BE ADMITTED TO CAMP WITHOUT THIS AND OTHER LISTED MEDICAL FORMS.)

A physical exam performed within thelast 18 months is required to be attached to this form - OR - the bottom of this page must be completed and signed by an appropriate medical authority. Immunization records are required to be submitted in the form of an "Immunization Certificate."

Camp: _____ Camp Location: _____ Camp Dates: _____

Camper/Staff Name: _____ Sex: _____ Age: _____ Height: _____ Weight: _____

Address: _____

Number and Street (and Apartment) *City* *State* *Zip Code*

Home Tel. #: _____

Parent/Guardian: _____ Tel. # (H): _____ Tel. # (W): _____

Emergency Contact: Name: _____ Tel. #: _____

The camp health staff may administer the following over-the-counter medications: ☐Tylenol ® or generic ☐Advil ® or generic ☐Neither

The camper or staff member may self-administer the following: ☐Inhaler ☐Epi-pen ☐Neither

HEALTH INSURANCE

Carrier: _____ Policy Number: _____

Policy Holder: _____ Holder's DOB: _____

I hereby certify that the named camper/staff is physically able to participate in the Camp and that I know of no restrictions, physical impairments, or any other condition, other than noted below, which would limit, in any manner, his or her participation in this program.

I hereby give permission for the camp health staff to dispense the prescription medications listed below. I hereby give permission for the named camper/staff to receive emergency medical or surgical treatment and hospitalization if necessary. I understand that every attempt will be made to contact me, or the emergency contact named above, before taking this action. I UNDERSTAND THAT THERE IS RISK OF INJURY TO THE NAMED CAMPER/STAFF AS A RESULT OF CAMP ACTIVITIES, AND KNOWINGLY AND VOLUNTARILY ASSUME ALL RISK OF SUCH INJURY. I will be financially responsible for any medical attention needed during camp or resulting from an injury received at camp. My medical insurance shall be the insurance coverage for any medical treatment.

_____ _____

Signature of Parent or Guardian (or staff member, if over 18) ***Date Signed***

HEALTH RECORD AND EXAMINATION

*** **Immunizations:** In accordance with current Centers for Disease Control guidelines. (Attach your child's "Immunization Certificate" Forms) ***

Allergies? ☐Yes ☐No Explain: _____

Special Diet? ☐Yes ☐No Explain: _____

Special Needs? ☐Yes ☐No Explain: _____

Prescription Meds.? ☐Yes ☐No Explain: _____

Other Pertinent Medical Information: _____

I certify that I have physically examined the above named camper, and that the individual ☐Is ☐Is not able to participate in all camp activities.
(If "Is not" please explain restrictions:) _____

Provider's Name: _____ License # and State: _____

Provider's Address: _____

_____ _____

Medical Provider's Signature ***Date Signed***