

Youth Camp Medical Information and Release Form

CAMP PARTICIPANT INFORMATION:

NAME OF YOUTH CAMP: _____

NAME OF CAMP PARTICIPANT: _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

DATE OF BIRTH: _____ **SEX:** _____ **HEIGHT:** _____ **WEIGHT:** _____

PARENT (or guardian) NAME: _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

CELL PHONE: () _____ **EMERGENCY PHONE:** () _____

EMERGENCY CONTACT NAME: _____ **RELATION:** _____

CELL PHONE: () _____ **EMERGENCY PHONE:** () _____

PRIMARY CARE PHYSICIAN: _____ **PHONE:** () _____

DO YOU HAVE HEALTH INSURANCE? YES: _____ NO: _____

NAME OF CARRIER

POLICY NUMBER

NAME OF PRIMARY INSURED

A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD MUST BE ATTACHED.

Does the Camp Participant have any chronic or acute medical problems? YES: _____ NO: _____

Please explain: _____

List any allergies to food, pollen, or medicine: _____

List any medications being taken at present time: _____

List any other conditions we should be aware of: _____

My child has permission to attend a youth camp on the University of North Texas at Dallas campus. I fully realize that injury or illness to my child may result from or during participation in the youth camp. In case of injury or illness, I give permission for my child to be given medical treatment as deemed appropriate. I further give permission for the information provided on this form to be shared with appropriate medical personnel. I further give permission for and grant authority to the camp representatives to sign on my behalf the Notice of Privacy Practice that patients are required to receive in accordance with federal law. I understand and acknowledge that I will be responsible for any medical bills incurred by my child at a local hospital or elsewhere.

Signature: _____ **Date:** _____