

# Rip & Ride Lacrosse and Ski Camps for Girls

Camper's Name \_\_\_\_\_

## Rip & Ride Winter Camp Health Form

This form must be completed and signed by the camper's legal guardian. The information we ask you to provide is necessary in the event your child needs medical treatment while camp is in session. This form will be returned to you if it is incomplete. Please type or print in black ink.

### CAMPER INFORMATION

Camper's Name \_\_\_\_\_  
Camper's Cell phone Number \_\_\_\_\_  
Permanent Address \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_  
City/State/Zip \_\_\_\_\_ Home Phone \_\_\_\_\_  
Email \_\_\_\_\_ High School \_\_\_\_\_ High School Grad Year \_\_\_\_\_

### MEDICAL EMERGENCY CONTACT INFORMATION

<i>Person to contact first:</i>	<i>Backup contact (relative or friend):</i>
Name _____	Name _____
Relation to camper _____	Relation to camper _____
Daytime Phone _____	Daytime Phone _____
Evening Phone _____	Evening Phone _____

### INSURANCE POLICY INFORMATION

The above-named child is covered by health insurance: Yes No  
If yes, provide the following information which is required by Hospitals to expedite treatment and to facilitate the billing process.

Policy Holder's (P.H.) Name \_\_\_\_\_ P.H.'s Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_ Relation to camper \_\_\_\_\_  
City/State/Zip \_\_\_\_\_ Occupation \_\_\_\_\_  
P.H.'s Employer \_\_\_\_\_  
Employer's Address \_\_\_\_\_  
Insurance Company \_\_\_\_\_  
Insurance Company's Address \_\_\_\_\_  
Policy # \_\_\_\_\_ Plan # \_\_\_\_\_

### MEDICAL TREATMENT CONSENT

I, the legal guardian of the above-named camper, authorize the Rip & Ride Camp staff to seek medical treatment for the camper as they see necessary at the Local Hospital or another nearby facility. I consent to any x-ray, anesthetic, medical or surgical diagnosis or treatment and hospital care subsequently deemed necessary by a licensed health care provider during the camper's session. I understand that this authorization is given in advance of any specific diagnosis, treatment or hospital care, and that it is given to provide the camp staff authority to seek medical treatment, and to provide a licensed health care provider the authority to administer this treatment as s/he judges necessary to the above-named child. I accept responsibility for payment of all services rendered; I authorize any medical facility which renders services to release medical information necessary for the processing of insurance claims; and I authorize the payment of insurance claims directly to the medical facility. I understand that whenever possible, the Camp staff will make a good faith effort to contact me or the above-named person(s) before seeking treatment. If this is not possible, I understand that the Camp staff will notify me or my designee as soon as possible if any and all diagnoses and treatments are made.

\_\_\_\_\_  
Legal Guardian's Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

# Rip & Ride Lacrosse and Ski Camps for Girls

Camper's Name \_\_\_\_\_

Directions: Completion of this form by a parent or guardian is required before a student can enter camp. Please answer all questions. Incomplete forms will be returned to you for the missing information. Please type or print in black ink. Attach any specific recommendations from your physician to this form.

## DOES THE CAMPER CURRENTLY HAVE ANY OF THE FOLLOWING? (if yes, please describe)

Drug allergies: \_\_\_\_\_

Food allergies: \_\_\_\_\_

Allergies to insect bites: \_\_\_\_\_

Special dietary needs: \_\_\_\_\_

Asthma: \_\_\_\_\_

Frequent headaches: \_\_\_\_\_

Dizziness or seizures: \_\_\_\_\_

LIST: Other health problems: \_\_\_\_\_

Limitations of Activities: \_\_\_\_\_

Medications the camper is currently taking: \_\_\_\_\_

**(please note:** Our staff cannot administer any medications, prescription or non-prescription to campers. This includes over-the-counter medicines like Advil or Tylenol for minor headaches or pains. If the camper will need to take medications while attending our program, s/he must bring the medication to camp and assume responsibility for taking it as needed or indicated.)

Will your son/daughter require any specific treatment for a medical/emotional condition while participating in our program? If yes, please explain. Yes No

## MEDICAL HISTORY

### IMMUNIZATION DATES:

Measles \_\_\_\_\_

Mumps \_\_\_\_\_

Rubella \_\_\_\_\_

OR MMR \_\_\_\_\_

Last Tetanus \_\_\_\_\_

(DPT, TT, or TD)

Polio Series completes \_\_\_\_\_

Date of last medical check-up: \_\_\_\_\_

Reasons for any hospitalization in past 5 years:

### PHYSICIAN'S INFORMATION (to be completed by physician) Please PRINT the following information:

Physician's Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_

*I have examined the above named camper and found her to be able to participate in all activities of the Rip and Ride Lacrosse and Ski Camp.*

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date