

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

Person to contact first:

Name _____
Relation to camper _____
Daytime Phone _____
Evening Phone _____

Backup contact (relative or friend):

Name _____
Relation to camper _____
Daytime 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