

HEALTH HISTORY OF _____
(child's name)

Allergic Reactions: Bee Sting _____ Penicillin _____ Other _____

Additional Information _____

Any Specific Activities To Be Encouraged/Restricted _____

Does This Child Have Any Special Needs That The Volunteer Staff Needs To Know?

Has Camper Been Exposed To Any Communicable Disease During Last 3 Weeks? _____
If Yes When/What _____

Any Accidents _____

List any medications currently taking and for what.

Health Insurance Carrier/Policy Number _____

ACKNOWLEDGMENT AND RELEASE

(a) I acknowledge that the information set forth above is complete and accurate;

(b) I release Panhandle South Plains Lutheran Camp Association (PSPLCA), its directors, officers, staff and agents from all claims, demands, actions or causes of action that I may have, now or in the future, relating to or resulting from any illness or injuries (including death) suffered by my child or his/her possessions while participating as a camper; and

(c) In case of Medical Emergency, I understand that every effort will be made to contact me as Parent/Guardian. In the event I cannot be reached, I hereby give my permission to the Physician selected by the Camp Director to hospitalize, secure proper treatment for, and to order injections, anesthesia or surgery for my child, as named above, and I accept full financial responsibility for any fees or expenses relating to this treatment.

Date _____

Parent/Guardian (PRINT) _____

Parent/Guardian (SIGNATURE) _____

Phone number(s) _____