

# HEALTH & RELEASE FORM FOR CAMPERS AND STAFF

(CHILDREN WILL NOT BE ADMITTED TO CAMP WITHOUT THIS FORM.)

**NOTE: PARENTS COMPLETE AND SIGN TOP HALF. PHYSICIAN COMPLETES AND SIGNS BOTTOM HALF REGARDING IMMUNIZATIONS OR PARENT SUBMITS IMMUNIZATION RECORD**

Camp: Williamstown Youth Center  
Camp Location: 66 School Street, Williamstown, MA  
Camp Dates: July 1, 2019 – August 23, 2019

Camper/Staff Name: \_\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
Address: \_\_\_\_\_  
*Number and Street (and Apartment) City State Zip Code*

Home Tel. #: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Tel. # (H): \_\_\_\_\_ Tel. # (C): \_\_\_\_\_  
Emergency Contact: Name: \_\_\_\_\_ Tel. #: \_\_\_\_\_  
Location if traveling during camp: \_\_\_\_\_ Tel. #: \_\_\_\_\_

## HEALTH HISTORY/TRANSPORTATION

Physical Restrictions: \_\_\_\_\_

Medications: A separate Prescription Medication Record Form must be completed for each medication. \_\_\_\_\_

Medical History a/o Medical Condition(s) which would require special attention: \_\_\_\_\_

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  
Transportation: I acknowledge that some activities require transportation by bus, van, or car and provide permission for my child(ren) to use transportation provided by the Williamstown Youth Center. \_\_\_ Yes or \_\_\_ No

## 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 Sports Camp and that I know of no restrictions, physical impairments, or any other condition, other than noted above, 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 above. 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. I also understand that it is my responsibility to apply sunscreen to my child(ren) before camp each day.*

\_\_\_\_\_  
*Signature of Parent or Guardian (or staff member, if over 18)*

\_\_\_\_\_  
*Date Signed*

## HEALTH RECORD

| <b>Immunizations</b>                      | <b>Dates Administered</b> |  |  |
|---|---------------------------|--|--|
| MMR Vaccine (1 MMR, 1 additional Measles) |                           |  |  |
| Measles                                   |                           |  |  |
| Mumps                                     |                           |  |  |
| Rubella                                   |                           |  |  |
| Polio (3 doses)                           |                           |  |  |
| Diphtheria/Tetanus/Pertussis (4 doses)    |                           |  |  |
| Hepatitis B (3 doses)                     |                           |  |  |

Medical problems, restrictions, limitations, etc. \_\_\_\_\_  
Physician's Name: \_\_\_\_\_ License # and State: \_\_\_\_\_  
Address: \_\_\_\_\_

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

\_\_\_\_\_  
*Date Signed*