1L younglife

CAMPING HEALTH, CONSENT AND RELEASE FORM

FOR AREA DIRECTORS

Camper ☐ Leader ☐ A-Team ☐

Work Crew 🗖

Area # _____ Area Name ____ Trip Leader/Area Dir. _

School Name _ Camp Dates _

Summer Staff

Information in this document is protected by HIPAA privacy laws and should be handled accordingly.

This form is only good for travel to and from, and attendance at, this specific camp; it may not be used for any other camping trip. A new form must be completed for each Young Life Camp experience.

Note to Parent/Guardian/Guest: Young Life wants the camp experience to be a safe and healthy one. However, in the event of an accident or illness, it is important that we have the following information:

- Medical history;
- 2. Medical insurance information; and
- Proof of physical examination, verified by Physician's signature, required fo

Name and phone of family physician (if attending camp outside of CO & MN)_

Name and phone of dentist/orthodontist

Please make a copy for your reco	-			Emai	l <u>'</u>
Name	Middle Initial		Birthdate	Sex _	Age
Parent or Guardian (or spouse)				Cell Phone ()
Home Address				Home Phone ()
Street Address Business Address)
Second Parent or Guardian Emergency Cor					
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Home AddressStreet Address	City	State/Province	Zip	Home Phone ()
Business Address	City	State/Province	Zip	Phone ()
f not available in an emergency, notify: Nan	•				
Home Address	City	State/Province	Zip	Home Phone ()
Street Address	City	State/F10VIIICE	<u>د</u> اب		
CIDENT COVERAGE derstand that my personal insurance will be prim dental claims). Exception: if the total claim is less luctibles and co-pays. Young Life's policy does no	than \$250, Young Life will pay	the full amount. On	claims above \$2	50, Young Life will co	pordinate payments for
My insurance company				_	
,			_ Policy Num	oer	
Insurance company address Not currently insured – Young Life reserved alth Care Recommendations: A physicia camps located in CO or MN, or a pregna	es the right to subrogation in a signature must be on the teen up to 34 weeks or	if it is later determ	ined that perso	nal medical insura	ance was in place. attending Beyond Malibu,
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	IZATION HISTORY: Required immuni month and year of basic immunizations		rmined locally.	HEALTH HISTORY (Give approximate dates)		
	Diptheria	1	1	Frequent Ear Infections	Chicken Pox	Epilepsy
	Pertussis (Whooping Cough)	2	2	Heart Defect/Disease	Measles	Mononucleosis
	Tetanus	3	3	Diabetes	German Measles	Convulsions
TD:	Tetanus			Bleeding/Clotting Disorder	Mumps	last 60 days
	Diptheria			Hypertension	Hepatitis A	Sickle Cell
	io (Sabin) TOPV			Currently Pregnant	Hepatitis B	
	e Polio (SALK)				Hepatitis C	
	II (Measles, Mumps, Rubella)			in last 10 weeks		
Other				Allergies/Asthma (Date not needed)		
	lin test given (most recent)			Hay Fever	Penicillin	
	hilus influenza b (HIB)			Ivy Poisoning, etc.	Other Drugs	
Hepatitis	Pox (New York camps only)			Insect Stings Other (specify)	Asthma	
Official	T OX (New York dumps only)			Outer (openly)		
				NSPORTATION ARRANGEMENTS		:
	owing people are NOT allowed to					
3ignatu	re of parent/guardian				Date	<u> </u>
AUTHO	DRIZATION FOR TREATMENT					
This hea	Ith history is correct to the best of my	knowledge, and the	person herein name	ed has permission to engage in all camp activities	except as noted. I hereby give p	permission to the medical
				aintain and/or release any medical records neces		
				child. In an emergency, I hereby give permission		
				other emergency medical procedures which may		
				erstood that this consent is given in advance of a d physician or dentist to exercise their best judgm		
	r surgical treatment. In addition, I autho				ient as to the requirements of st	deri diagnosis di medical,
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