

Medical History and Treatment Permission for Camp Participants

This form is required for all participants, please complete and submit at registration *Please Print*

Camp/Activity Name _____
Attendance Dates _____ to _____ <i>Start Date</i> <i>End Date</i>

Participant Information

Name _____
First Name *Middle* *Last*

Age _____ Date of Birth _____ Social Security # _____

Home Address _____

Father/Guardian Name _____

Address _____

Phone: Home () _____ Work () _____ Cell () _____ Pager () _____

Mother/Guardian Name _____

Address _____

Phone: Home () _____ Work () _____ Cell () _____ Pager () _____

Other Contact Person

Phone: Home () _____ Work () _____ Cell () _____ Pager () _____

Family Physician _____ **Phone #:** () _____

Medical History: *(Please use, back of this sheet if necessary)* **Date of last tetanus booster** _____

Allergies: Insect bites/stings *(please list)* _____
 Food *(please list)* _____
 Drug *(please list)* _____
 Other *(please list)* _____

Is the participant under the care of a provider for a medical and/or psychological problem? Yes ___ No ___
If yes, please explain: _____

Is the participant taking medication prescribed by a health care provider? Yes ___ No ___
If yes, please explain: _____

Other information we should be aware of ? _____

Payment Information for care and treatment received at Wardenburg Health Center an the University of Colorado at Boulder campus: Unless your Camp is insured through University Risk Management, cash, check, or credit card payment is required at time of service These charges will not be billed to your insurance company. Please provide credit card information for a card valid during the dates of attendance at the event above.

Visa _____ Master Card _____ Expiration Date _____ Credit Card # _____

Name on the Card _____ Signature _____

Parental/Guardian Permission: I give my permission for diagnostic and therapeutic procedures as may be necessary for the above named participant by any licensed health care facility. I understand that the health care facility will make a reasonable attempt to contact me first, if time and conditions permit. **I agree to be responsible for all charges incurred.**

Name *(Printed)* _____ Signature: _____

Date _____ Relationship to Participant _____