Health and Release Form

Campers Name: _____ Date of Birth: _____
Home Address: _____ Phone Number: _____
Parent's Names and Cell Phones:_____
Emergency Contact's Names and Cell Phones:_____

Allergies/Drug Reaction:
Aspirin: Yes___No___
Penicillin: Yes__No____
Sulfa: Yes__No____
Bee Stings: Yes__No____
If YES, does he/she carry and Epi Pen:___
FOOD ALLERGIES: Please List
_____
_____
Other:_____

Current Medications to be administered while at camp(w/instructions):
_____
_____

Health History
Asthma: Yes/ No Diabetes: Yes/ No
Epilepsy: Yes/ No Heart problems: Yes/ No
Head Injuries: Yes / No Mono: Yes / No
Orthopedic injuries (within past six months):_____
_____

Heath Insurance Information: (Please enclose a copy of both sides of your insurance card)
Insurance Company Name:_____Policy Holder:_____
Policy Number:_____Group Number:_____
Insurance Co. Address and Phone #:_____

****Please remember to attach a copy of your child's **"Certificate of Immunization".** You may either fill out the immunization form or obtain a printout from the doctor. ****

I certify that I have reviewed the medical history and status of the above person, and certify that he/she has no medical problems that restrict him/her from participation in vigorous physical activity while at Just Play Elite 200 ID Camp.
Physician's Name: _____ Phone #: _____
Physician's Signature: _____ Date: _____

I, the parent (guardian) of _____ give permission for the named camper 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 hereby waive and release Just Play Elite 200 ID Camp and Staff from any liability for any injury or illness incurred while at camp. I understand that there is a risk of injury to the named camper 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 coverage shall be the insurance coverage for any medical treatment. I have read the rules and regulations of camp and both camper and I agree to abide by them.

Parent/Guardian Name: _____
Parent/Guardian Signature: _____

CERTIFICATE OF IMMUNIZATION

Name:

Date of Birth: / / **Sex:** □**female** □**male**

If combination vaccine is administered, please indicate vaccine type (e.g., DTaP-Hib, etc.)

Vaccine		**Date/Vaccine Type**	**Vaccine**		**Date/Vaccine Type**
Hepatitis B (e.g., HepB, HepB-Hib, DTaP-HepB-IPV)	1		***Haemophilus influenzae* type b** (e.g., Hib, HepB-Hib, DTaP-Hib)	1	
	2			2	
	3			3	
Diphtheria, Tetanus, Pertussis (e.g., DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, Td)	1			4	
	2		**Measles, Mumps, Rubella** (MMR)	1	
	3			2	
	4		**Varicella** (Var)	1	
	5			2	
	6		**Hepatitis A** (HepA)	1	
	7			2	
Polio (e.g., IPV, DTaP-HepB-IPV)	1		**Pneumococcal Polysaccharide** (PPV23)	1	
	2			2	
	3		**Influenza** Inactivated (Intramuscular) or Live (Intranasal)	1	
	4			2	
Pneumococcal Conjugate (PCV7)	1			3	
	2		**Other:**		
	3				
	4				

Serologic Proof of Immunity		**Check One**	
Test (if done)	Date of Test	Positive	Negative
Measles	/ /		
Mumps	/ /		
Rubella	/ /		
Varicella*	/ /		
Hepatitis B	/ /		
* Must also check Chickenpox History box.			

Chickenpox History

☐ Check the box if this person has a physician-certified reliable history of chickenpox.

Reliable history may be based on:

- physician interpretation of parent/guardian description of chickenpox
- physical diagnosis of chickenpox, or
- serologic proof of immunity

I certify that this immunization information was transferred from the above-named individual's medical records.

Doctor/nurse's name and facility name *(please print)* **Date:** / /

Signature: