

New & returning campers are required to COMPLETE, SIGN & RETURN BOTH SIDES OF THIS FORM. Please use one form per camper. A photocopy is acceptable. All information will be kept confidential. PLEASE PRINT CLEARLY.

## HEALTH & PERMISSION FORM

Child's Name \_\_\_\_\_

Birth Date (Mo/Day/Yr) \_\_\_\_\_

Age \_\_\_\_\_

Grade (as of 9/09) \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_

Phone # \_\_\_\_\_

Phone # \_\_\_\_\_

Cell # \_\_\_\_\_

Cell # \_\_\_\_\_

Alternate # \_\_\_\_\_

Alternate # \_\_\_\_\_

### ALTERNATE EMERGENCY CONTACTS IF A PARENT/GUARDIAN CANNOT BE REACHED

Name \_\_\_\_\_

Name \_\_\_\_\_

Phone # \_\_\_\_\_

Phone # \_\_\_\_\_

Cell # \_\_\_\_\_

Cell # \_\_\_\_\_

Alternate # \_\_\_\_\_

Alternate # \_\_\_\_\_

Relationship to child \_\_\_\_\_

Relationship to child \_\_\_\_\_

HEALTH HISTORY: On the back of this form, please list any medical conditions your child has including: a recent/current illness or injury, existing medical condition, restriction or limitations, seizure disorders, asthma, allergies (i.e., to medications, insect stings, food, etc.) or special needs. Also list any medication taken by the camper at home or during camp hours.

Does the child carry an EPI-Pen \_\_\_\_\_

Insulin \_\_\_\_\_

Other \_\_\_\_\_

Please be aware that camp staff are not authorized to administer any medication, prescription or non-prescription.

Doctor's Name \_\_\_\_\_

Phone # \_\_\_\_\_

Medical Insurance Co. \_\_\_\_\_

Policy # \_\_\_\_\_

Hospital Preference \_\_\_\_\_

IMMUNIZATION DATES	1st Dose	2d Dose	3rd Dose	Booster	Booster
Measles	_____	_____			
Mumps	_____				
Rubella	_____				
OPV	_____	_____	_____	_____	
DPT	_____	_____	_____	_____	_____
HIB	_____	_____	_____	_____	_____
Hepatitis B	_____	_____	_____	_____	
Varicella (Chicken Pox)	_____				

I give permission for my child noted above to receive medical treatment in case of illness or injury during camp hours. I authorize transportation to a hospital and permission to release his/her medical information. I understand that I am responsible for all payments for medical treatments. Please initial here: \_\_\_\_\_

Please complete both sides of this document

- I understand that my child will not be admitted to a riding week unless this form (both sides) is completed and returned.
- I hereby give permission for my child to attend and take part in all riding week activities except as noted by his/her physician.
- I understand I give permission for all those responsible for my child to be informed of any restrictions or medical conditions that will impact my child's well-being during riding week, i.e., seizures, asthma, allergies, etc. Please initial here: \_\_\_\_\_
- I give Frog Hollow Farm staff permission to apply topical insect repellent and/or sun block which I will provide. Please put your child's name on the product's original plastic container with a permanent marker.
- I understand that Frog Hollow Farm is not responsible for lost belongings. Items will be held for two weeks after the riding week has ended. If the child's name is on the item, we will call to notify.
- Frog Hollow Farm may use photographs of this child for publicity and/or promotional materials. YES/NO

I have read, completed, and agree to the information on this Health & Permission Form.

Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

HEALTH HISTORY INFORMATION (see other side):

Please complete both sides of this document.