Saint Mary's Parish

519 Longmeadow Street
Longmeadow, Massachusetts 01106

Telephone: (413) 567-3124 email: kbladen@stmarylong.org

Summer Camp Health, Consent & Release Form

Name: _____ Birthdate _____
Last First MI

Recommendations and Restrictions While at Camp

Any Treatment to be continued at camp_____
Any medication to be administered at camp (specific dosages) _____
_____
Any medically prescribed meal plan or dietary restrictions _____
Any Allergies (Food, drugs, plants, insects) _____
Additional health information/activities to be limited_____
Operations or serious injuries (Dates) _____
Chronic or recurring illness or medical condition _____
Dietary Restrictions _____
Current Medications (send in prescription bottles) _____
Other Disease_____
Name of Family Physician _____
Name of Dentist/orthodontist _____
Special Health and behavioral considerations_____

Health History: (give approx. dates)

_____Frequent Ear Infections
_____Heart Defect/Disease
_____Diabetes
_____Bleeding/Clotting Disorder
_____Hypertension
_____Mononucleosis
_____Convulsions
_____Epilepsy
_____Chicken Pox
_____Measles
_____German Measles
_____Mumps
_____Hepatitis A
_____Hepatitis B
_____Hepatitis C

Allergies (Date not needed)

_____Hay Fever
_____Ivy Poisoning
_____Insect Stings
_____Penicillin
_____Asthma
_____Other (Specify)_____
_____Other drugs

Authorization for treatment:

This health history is correct as far as I know, and the person herein described has permission to engage in all camp activities except as noted. I hereby give permission to the medical personnel selected by the camp director to order x-rays, routine tests, treatment; to maintain and/or release any medical records necessary for insurance purposes as outlined under the HIPAA regulations; and to provide or arrange necessary related transportation for me or my child. In an emergency, I hereby give permission and authorize the physician selected by Saint Mary's Summer Camp to secure or administer emergency medical treatment, including hospitalization and any other emergency medical procedures which may be needed for the person named above. I authorize the physician or dentist to call any necessary consultants in his/her discretion. It is understood that this consent is given in advance of any specific diagnosis or treatment being required but is given to encourage those persons who have temporary custody of the minor and said physician or dentist to exercise their best judgement as to the requirements of such diagnosis or medical, dental, or surgical treatment.

I agree to remain fully liable and responsible for the payment of any such hospital, doctor, ambulance, dental, or medical fees. I further agree that in giving this permission and authorization, St, Mary's does not assume any responsibility or liability for the payment of such hospital, doctor, ambulance, dental or medical fees which may be incurred.

Signature of parent or guardian: _____Date_____

This form MUST accompany up-to-date immunization/vaccine records from a doctor's office. Our health/consent form does not require a doctor's signature.