



# One United Youth Camp

## YOUTH CAMP MEDICAL INFORMATION AND RELEASE FORM

NAME OF CAMP PARTICIPANT: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SEX: \_\_\_\_\_

HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_

PARENT (or guardian) NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

CELL PHONE: ( ) \_\_\_\_\_ EMERGENCY PHONE: ( ) \_\_\_\_\_

EMERGENCY CONTACT NAME: \_\_\_\_\_ RELATION: \_\_\_\_\_

CELL PHONE: ( ) \_\_\_\_\_ EMERGENCY PHONE: ( ) \_\_\_\_\_

PRIMARY CARE PHYSICIAN: \_\_\_\_\_ PHONE: ( ) \_\_\_\_\_

DO YOU HAVE HEALTH INSURANCE? YES: \_\_\_\_\_ NO: \_\_\_\_\_

_____	_____	_____
NAME OF CARRIER	POLICY NUMBER	Name of Primary Insured

**A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD MUST BE ATTACHED.**

Does the Camp Participant have any chronic or acute medical problems? YES: \_\_\_\_\_ NO: \_\_\_\_\_

Please explain: \_\_\_\_\_

List any allergies to food, pollen, or medicine: \_\_\_\_\_

List any medications being taken at present time: \_\_\_\_\_

List any other conditions we should be aware of: \_\_\_\_\_

My child has permission to attend the ONE United youth camp, located at Tejas Camp & Retreat facility in Giddings, TX. I fully realize that injury or illness to my child may result from or during participation in the youth camp. In case of injury or illness, I give permission for my child to be given medical treatment as deemed appropriate. I further give permission for the information provided on this form to be shared with appropriate medical personnel. I further give permission for and grant authority to the camp representatives to sign on my behalf the Notice of Privacy Practice that patients are required to receive in accordance with federal law. I understand and acknowledge that I will be responsible for any medical bills incurred by my child at a local hospital or elsewhere.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_