STANFORD UNIVERSITY
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 _____

HOME PHONE: ( ) _____WORK PHONE:( ) _____

EMERGENCY CONTACT _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE: ( ) _____WORK PHONE:( ) _____

PRIMARY CARE PHYSICIAN: _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE: ( ) _____

Please give us the name of your health/accident insurance carrier(s) and appropriate policy certificate number (s):

_____ _____

NAME OF CARRIER POLICY NUMBER

PLEASE ATTACH A COPY OF YOUR INSURANCE CARD.

Does this student have any chronic or acute medical problems?

_____

Please explain: _____

List any allergies to food, pollen, or medicine: _____

_____

List any medications being taken at present time: _____

_____

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.

Parent or Legal Guardian: _____ Date: _____