STANFORD UNIVERSITY CAMP MEDICAL INFORMATION AND RELEASE FORM

| NAME OF CAMP PAR | RTICIPANT | nanninnallannannannahii (Tiralliili (Tilalliili (Tilalliili (Tilallii (Tilal | | | ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~ |
|--------------------------------------|---|--|--|---|--|
| ADDRESS | | ;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;; | 00000000000000000000000000000000000000 | gennessen and de fair de la fair | INTERENTALISEN NEUTEN STEKKEPTET KOMMEN KANTAN TERMINING NEUTEN KANTAN KANTAN KANTAN KANTAN KANTAN KANTAN KANT |
| CITY | 20000000000000000000000000000000000000 | odoccoccoccoccoccoccoccoccoccoccoccoccoc | STATE | 5000860nh6nnd577no/777048600000000000 | ZIP |
| DATE OF BIRTH | | SEX. | HEIGI | IT. | WEIGHT |
| PARENT (or Guardian) |) NAME | ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~ | 000000000000000000000000000000000000000 | 00000000000000000000000000000000000000 | |
| ADDRESS | ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~ | 00000000000000000000000000000000000000 | | 00000000000000000000000000000000000000 | 90000000000000000000000000000000000000 |
| CITY | | | STATE | | ZIP |
| HOME PHONE: (| > | WORK | PHONE:(|) | |
| EMERGENCY CONT. | ACT | | | | \$2772477788427824784474784444000000000000 |
| ADDRESS | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | oonneen on a see a s | | hasilasilanoskaskaskaskaskaskaskaskaskaskaskaskaskas | ~~^^^^^ |
| CITY | | v _{KN} uvouvougagaguuvuuvuvuosogovoooooooooooooooooooooooo | STATE | 000000000000000000000000000000000000000 | ZIP |
| HOME PHONE: (| > | WORK | PHONE:(|) | 200hn4nhnnnn4n4nnhannnnaannaannaannaannaann |
| PRIMARY CARE PHY | YSICIAN: | 88X-90405644548544445-95469555990909090909090909090000000000 | ************************************** | 000000000000000000000000000000000000000 | Dullarularularunannannannannannannannannannannannannan |
| ADDRESS | | 2000-1000-1000-1000-1000-1000-1000-1000 | *************************************** | | |
| CITY | 10000000000000000000000000000000000000 | | STATE | | ZIP |
| HOME PHONE: (| > | xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx | | | |
| Please give us the name | e of your health/accide | ent insurance carrier | s) and approp | riate polic | y certificate number (s): |
| NAME | OF CARRIER | nnoundunandundovidosidus | *************************************** | POLI | CY NUMBER |
| PLEASE ATTACH Does this student have | | | CARD. | | |
| Please explain: | | | | | |
| List any allergies to | food, pollen, or me | dicine: | ahnanasariirikodnasihohennasarasarennasanananananana | | ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~ |
| List any medications b | eing taken at present | time: | | | |
| the information provided | for my child to be given on this form to be share up representatives to sig | n medical treatment and with appropriate monage on my behalf the N | s deemed approduced cal personne of Privac | opriate. I i I. I furthe y Practice i | further give permission for give permission for and that patients are required to |
| Parent or Legal Guardi | an: | xxxx00uuucco8000occo5cco5555500000000000000000000 | | Date: | <3/46/65/68/68/68/68/68/68/68/68/68/68/68/68/68/ |