ASTRONOMY CAMP MEDICAL RELEASE

please print all information; continue on back side if necessary

STUDENT:

Full name: _____

Social Security Number: _____ (for emergency use only)

Birth date: _____

Present health: _____

Past injuries: _____

MEDICATIONS:

Drug allergies & sensitivities: _____

Date of last tetanus booster: _____

Are immunizations up-to-date? **YES or NO** (If NO, please explain on back of this form)

Medications (prescription & over-the-counter) I will require at Camp:

List kinds and frequencies _____

_____

DIETARY:

Restrictions: _____

Food allergies: _____

If "vegetarian," please elaborate (vegan?; do you eat dairy, fish, chicken?): _____

HEALTH INSURANCE:

Are you covered by health insurance? YES or NO

Please attach photocopies of both sides of your insurance card or claim form.

Company_____

Policy number_____

Address_____

City_____ State_____ Zip_____

LIST ALL medical conditions, physical or learning disabilities, etc.:

_____

_____

I agree to be treated by a licensed physician while attending Astronomy Camp, as may be necessary, and to assume all costs related to such treatment. I authorize my insurance company to pay benefits to any medical facility or hospitals. Also, I authorize the disclosure of medical information to my insurance company for the purpose of claim.

Signature_____ **Date**_____

Street Address_____

City_____ State_____Zip_____

Emergency contact: _____

Phones: (Home)_____ (Work)_____

(Cell)_____