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) student 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:

Is student 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, motion sickness, physical or learning disabilities, and any emotional or behavorial problems:

_____

_____

I agree to let my child 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. The above student has my permission to take the medications listed above as needed during the Camp.

Parent's Signature_____ **Date**_____

Street Address_____

City_____ State_____Zip_____

Phones: (Home)_____ (Work)_____

(Cell)_____

Emergency contact (other than parents): _____