Nature Center
AT SHAKER LAKES

Outdoor Adventure Camp Emergency Medical Authorization And Health Form

Complete both sides and return **before** your child's camp program.
One form per child is required to participate in camp.
To be completed by parent or guardian.

Purpose: Please provide complete information so that the staff can be aware of your child's needs and provide appropriate care. Any changes to this form should be submitted to camp personnel upon your child's arrival in camp.

Camper's Last Name_____ First Name_____ DOB ____/____/____ □ Male □ Female

Home Address_____ Phone_____

Parent or Guardian 1_____ Phone_____

Parent/Guardian 2_____ Phone_____

If Parent, Guardian are not available in an emergency, notify:

1_____ Phone_____

2_____ Phone_____

Other Person(s) Authorized to pick up your child:

1_____ Relationship: _____ Phone: _____

2_____ Relationship: _____ Phone: _____

Camper's physician_____ Phone_____

Address_____

Camper's dentist/orthodontist _____ Phone_____

Purpose: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under the Nature Center's authority, when parents or guardians can not be reached.

Important — Part I or Part II must be completed for camp attendance

Part I, CONSENT GRANTED

I, the undersigned, hereby give permission for my child to participate in all activities (unless otherwise specified) and assume all risks and hazards incidental to the program. I also hold harmless the Nature Center at Shaker Lakes, its staff, and appointed assistants. I also understand and agree to abide by any restrictions placed on my child's participation in camp activities.

Parent/Guardian Authorizations: This health history and any attached forms are correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted.

I hereby give permission to the Nature Center at Shaker Lakes to provide and seek emergency medical treatment and administer prescribed medications by certified staff. I agree to the release of any records necessary for insurance purposes. I give permission to the staff to arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician and dentist named above to administer treatment, including hospitalization at _____(named hospital) or any hospital reasonably accessible, for the camper named above. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists concurring on the necessity of such surgery are obtained prior to the performance of such surgery. This completed form may be photocopied.

Signature of Parent or Guardian: _____

Printed Name _____ Date _____

Part II, REFUSAL TO CONSENT

I do not give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the Nature Center authorities to take no action or to: _____

Signature of Parent/Guardian: _____ Date _____

All sections must be completed for attendance

Photo Release For Marketing Purposes

I give permission to the Nature Center at Shaker Lakes to make commercial, non-commercial, social media, and web content use of any activity photographs of my child during this program.

Signature of Parent/Guardian: _____ Date _____

I do not give permission to the Nature Center to photograph my child. **Signature:** _____

Please take the time to answer all questions. Write N/A if a question does not apply. DO NOT LEAVE BLANK

Dietary Needs: □ Kosher □ Vegetarian
Does not eat: □ Meat □ Pork □ Dairy products □ Wheat □ Peanuts □ Eggs □ Other _____

Allergies- Include medication, food and others (insect stings, hay fever, asthma, animal dander, etc.)
List all known. Describe reaction and management of the reaction.

_____ _____
_____ _____
_____ _____
_____ _____

Does your child carry an Epi E-Z Pen? _____

If yes, please explain _____

Special needs: List any of which the staff should be aware (medical, emotional, learning, social)

_____
_____

Explain any restrictions to activity (e.g., what cannot be done, what adaptations or limitations are necessary)

_____

Medications: Applies to medications that must be taken at lunch or for our overnight programs.
Please list ALL medications (including over-the-counter or non-prescription drugs) taken routinely. Bring enough medication to last the entire week of camp. Keep medication in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

☐ My child **takes NO medications** on a routine basis. OR ☐ My child **takes medications** as follows:
Med #1_____Dosage_____Specific times taken each day_____
Reason for taking_____
Med #2_____Dosage_____Specific times taken each day_____
Reason for taking_____
Attach additional pages for more medications.
Identify any medications taken during the school year that participant does/may not take during the summer:
_____
_____

Insurance Information *FOR OVERNIGHT CAMPERS ONLY*

Is the participant covered by family medical/hospital insurance? ☐ Yes ☐ No
If so, indicate carrier or plan name_____Group#_____
Carrier address_____
Name of insured_____ Relationship to participant_____
Social Security number of policy holder or Insurance ID number_____