KATY YOUTH CHOIR

2019 KYC SUMMER CAMP MEDICAL RELEASE FORM

Please complete and return the following information.

Parent/Guardian signature REQUIRED.

Please Circle Camp Attending: Lights of Broadway Camp (June 3-7) The Little Mermaid Camp (June 17-28)

General Information

Name: _____ Date of Birth: _____ **Male Female**

Address: _____ City: _____ State: ____ Zip: _____

Name of Parent/Guardian: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Emergency Contacts: *(other than parent/guardian listed above)*

1. Name: _____ Primary #: _____ Secondary #: _____

2. Name: _____ Primary #: _____ Secondary #: _____

Medical Information

Does your child suffer from any chronic or reoccurring condition or illness? If yes, please explain:

_____

Does your child need any medication while at camp? **Yes** **No**

If yes, please list below:

	Medication	**Dosage**	**Frequency**	**Reason**
1:				
2:				
3:				

Other Health Concerns

Please attach explanations as needed.

Physical Impairment restricting activities: _____

Bone/joint injury in past 12 months: _____

Major illness in past 12 months: _____

Significant allergies: _____

Other: _____

Health Care and Camp Permission

Parent/Guardian **MUST** initial and sign statements below

_____ Medical care is available at your expense and this expense will not be assumed by the Camp or Katy Youth Choir. I understand that in the event of serious illness or injury, Camp Administrators will seek professional medical attention including, but not limited to EMS transportation and hospitalization.

_____ I will not hold the Katy Youth Choir its officers and staff accountable for any illness, injury or death that should occur before, during or after camp hours.

_____ I will not hold Cane Island, its officers and staff accountable for any illness, injury or death that should occur before, during or after camp hours.

Health Plan Information

Insurance Provider Name: _____

Name of insurer: _____ Relationship to Camper: _____

Policy #: _____ Group #: _____

Doctor Information

Name of Primary Doctor: _____ Phone #: _____

Address: _____ City: _____ State: _____

Over the Counter Medication Release

I give permission for my child to be given the following medications according to the recommended dosage for age, of necessary *(please initial below):*

_____ Acetaminophen (Tylenol) _____ Ibuprofen (Advil) _____ Pepto-Bismol

_____ Anti-Diarrhea (Immodium) _____ Antihistamine (Benadryl)

Parent or Guardian Signature: _____ Date: _____

Student Signature (if over 12): _____ Date: _____