POWHATAN SUMMER CAMP HEALTH FORM

This form must be completed and signed by the participant's legal guardian. The information we ask you to provide is necessary in the event your child needs medical treatment while camp is in session. **You may email this to allisonjewell@powhatanschool.org or bring with you to first day of camp.**

PARTICIPANT INFORMATION

Participant's Name ____

Date of Birth ____

Sex____

Permanent Address ____

City/State/Zip ____

Home Phone ____

MEDICAL EMERGENCY CONTACT INFORMATION

Person to contact first:

Name ____

Relation ______________________________________

Daytime Phone ________________________________

Evening Phone_________________________________

Backup contact (relative or friend):

Name ______________________________

Relation ____________________________

Daytime Phone ______________________

Evening Phone ______________________

INSURANCE POLICY INFORMATION

The above-named child is covered by health insurance: Yes No

If yes, provide the following information which is required by Powhatan School to expedite treatment and to facilitate the billing process.

Policy Holder's (P.H.) Name_____________________________________

Relation ____

P.H.'s Date of Birth____

Address ____

City/State/Zip ____

Occupation____

P.H.'s Employer

____

Employer's Address

____

Insurance Company

____

Insurance Company's Address

____

Policy # ____

Plan #____

Directions: Completion of this form by a parent or guardian is required before a student can participate. Please answer all questions. **Incomplete forms will be returned to you for the missing information**. Please type or print in black ink. Attach any specific recommendations from your physician to this form.

DOES THE PARTICIPANT CURRENTLY HAVE ANY OF THE FOLLOWING? (if yes, please describe)

Drug allergies: ____

Food allergies: ____

Allergies to insect bites: ____

Special dietary needs: ____

Asthma: ____

Frequent headaches: ____

Dizziness or seizures: ____

LIST: Other health problems: ____

____

Limitations of Activities: ____

____

Medications the camper is currently taking: ______________________________

____

____

Will your son/daughter require any specific treatment for a medical/emotional condition while participating in our program? **YES or NO**

If yes, please explain:

____

____

MEDICAL HISTORY

(Please write year received)

Mumps ______________________

Rubella ______________________

OR MMR______________________

Last Tetanus ____________________

(DPT, TT or TD)

Polio Series completes ___________

Hospitalizations in the past 5 years: Describe:

____

____

____

____

____

____

PHYSICIAN'S INFORMATION

Physician's Name: ____

Address: ____

City/State/Zip ____

Telephone ____

MEDICAL TREATMENT CONSENT

I, the legal guardian of the above-named camper, authorize the Powhatan Summer Camp staff to seek medical treatment for the camper as they see necessary at Winchester Medical Center or another nearby facility. I consent to any x-ray, anesthetic, medical or surgical diagnosis or treatment and hospital care subsequently deemed necessary by a licensed health care provider during the participant's session. I understand that this authorization is given in advance of any specific diagnosis, treatment or hospital care, and that it is given to provide the program staff authority to seek medical treatment, and to provide a licensed health care provider the authority to administer this treatment as s/he judges necessary to the above-named child. I accept responsibility for payment of all services rendered; I authorize any medical facility which renders services to release medical information necessary for the processing of insurance claims; and I authorize the payment of insurance claims directly to the medical facility. I understand that whenever possible, the Program staff will make a good faith effort to contact me or the above-named person(s) before seeking treatment. If this is not possible, I understand that the Program staff will notify me or my designee as soon a possible of any and all diagnoses and treatments.

______________________	______________________	__________
Legal Guardian's Signature	Print Name	Date