This consent form gives permission to treat, dispense over-the-counter medications, and/or seek whatever medical attention is deemed necessary by our Camp Medical Staff; and releases Bluestone Camp & Retreat and its staff of any liability against personal losses of named child. Camp Medical Staff and/or the Camp Director will contact parent(s)/guardian(s) in any situation where it is determined that a child must be transported to the hospital or a local physicians office for treatment.

I/We the undersigned have legal custody of the child named above, a minor, and have given our consent for him/her to attend events being organized by Bluestone Camp & Retreat. I/We understand that there are inherent risks involved in any ministry or athletic event, and I/we hereby release Bluestone Camp & Retreat, its employees and volunteer workers from any and all liability for any injury, loss, or damage to person or property that may occur during the course of my/our child's involvement. In the event that he/she is injured and requires the attention of a doctor, I/we consent to any reasonable medical treatment as deemed necessary by a licensed physician. In the event treatment is required from a physician and/or hospital personnel designated by Bluestone Camp & Retreat, I/we agree to hold such person free and harmless of any claims, demands, or suits for damages arising from the giving of such consent. I/We also acknowledge that we will be ultimately responsible for the cost of any medical care should the cost of that medical care not be reimbursed by the health insurance provider. Further, I/we affirm that the health insurance information provided above is accurate at this date and will, to the best of my/our knowledge, still be in force for the child named above. I/we also agree to bring my/our child home at my/our own expense should they become ill or if deemed necessary by the Camp Director.

Parent/guardian signature: _____ Date: _____

Physical Examination (to be filled out and signed by examining physician/examiner)

Camper's Name: _____ **Birth date:** _____
Last **First** **Initial**

***Please cite abnormal findings**

Height (inches):_____ Weight: _____ Blood Pressure: _____/_____ (_____/_____, _____/_____)

Pulse(s):_____

Glasses: ☐ Contacts: ☐ (Wearing ☐) Vision: Right: 20/___ Left: 20/___ Pupils: Equal ☐ Unequal ☐

Ears/Nose/Throat: _____ Lungs: _____

Lymph Nodes: _____ Skin: _____ Heart: _____

Abdomen: _____ Hernia: _____ Testicles: _____

Deformities or present illness or other concern: _____

*I certify that I have examined the above student and I feel this individual may participate in all camp physical activities, except the following:

_____

_____

Name of examining physician (print please) Physician's address Phone

_____ _____
Signature of examining physician **Date**

Visual Health Screening (to be executed by Bluestone Medical Staff upon arrival at camp)

Observations: _____

Notes:

_____

Okay for Admission to Camp? yes ☐ no ☐ Initials: _____

Effective dates: _____ to _____

Bluestone Camp & Retreat

Medical Release Form

Please print in ink

Name: _____ Age _____ Birthday _____
LAST FIRST MIDDLE

Year in school _____ Male ☐ Female ☐ Email _____

Address _____ City _____ State _____ Zip _____

Primary Home Phone _____

Medical insurance company _____ Policy # _____

Mother's name _____ Phone: Work _____ Cell _____

Father's name _____ Phone: Work _____ Cell _____

Emergency contact _____ Phone: Work _____ Cell _____

Physician _____ Phone: Office _____

Medical History

If necessary, describe in detail the nature and severity of any physical and/or psychological ailment, illness, propensity, weakness, limitation, handicap, disability, or condition to which your child is subject and of which the staff should be aware, and what, if any action of protection is required on account thereof. Submit this notification in writing and attach it to this form. Include names of medications and dosages that must be taken.

Check the following areas of concern for this student. If necessary, add another page with details:

1. Does your child have allergies to—
   ☐ pollens? ☐ medications? ☐ insect bites? ☐ food? Please list any dietary restrictions:

   _____

2. Does your child suffer from, or has ever experienced, or is being treated currently for any of the following:
   ☐ asthma ☐ epilepsy / seizure disorder ☐ heart trouble ☐ diabetes
   ☐ frequently upset stomach ☐ physical handicap ☐ mental or psychological disorder

3. Is your child taking any prescribed or over-the-counter medications, or any medications that could impair their ability to participate in camp activities? _____

   _____

4. *** REQUIRED *** Please provide the date of last Tetanus Shot: _____

5. Are all of your child's immunizations up to date? ☐ yes ☐ no If no, please explain:

   _____

6. Please list and explain any major illnesses the child experienced during the last year:

   _____

7. Should this child's activities be restricted for any reason? Please explain:

   _____

   _____