ROCKY MOUNTAIN summer conservatory

MEDICAL RELEASE AND PHYSICAL EXAMINATION

STUDENT NAME:

STUDENT INFORMATION

Date of Birth:

☐ **Male** ☐ **Female**

Home Address:

Home Phone:

EMERGENCY CONTACT

In case of an emergency, please contact:

Name:

Relationship to Student:

Home Phone:

Mobile Phone:

Work Phone:

PHYSICAL EXAMINATION

This remainder of the form MUST be completed by a Licensed Medical Professional.

Date of last examination:

BP:

Weight:

Height:

Please complete all four (4) pages.

ROCKY MOUNTAIN summer conservatory

For the following, please feel free to attach additional sheet or document if necessary.

Which of the following has the student had?

- ❑ **Measles**
- ❑ **Chicken Pox**
- ❑ **German Measles**
- ❑ **Mumps**
- ❑ **Hepatitis**

TB Mantoux Test

Date of last test:

Result:

- ❑ **Positive**
- ❑ **Negative**

Please give dates of immunizations for:

Vaccine	Dates: Mo/Yr Mo/Yr Mo/Yr Mo/Yr Mo/Yr Mo/Yr
DTP	____ ____ ____ ____ ____ ____
TD	____ ____ ____ ____ ____ ____
Tetanus	____ ____ ____ ____ ____ ____
Polio	____ ____ ____ ____ ____
MMR	____ ____
or Measles	____ ____
or Mumps	____ ____
or Rubella	____ ____
Haemophilus influenza B	____ ____ ____ ____
Hapetitis B	____ ____ ____
Varicella (chicken pox)	____ ____
BGG	____

In my opinion, the above applicant ❑ is ❑ is not able to participate in an active camp program.

The applicant is under the care of a physician for the following conditions:

Current treatment at the time of this report includes:

Please complete all four (4) pages.

RECOMMENDATION AND RESTRICTIONS

Please list any treatment to be monitored while camp is in session.

MEDICATIONS

Please list any medications (including over-the-counter) to be taken while attending RMSC (name, dosage, frequency). Please note, RMSC staff will monitor but not administer medications.

Please list medications taken during the school year that will be suspended for the summer.

Please list any medically-prescribed meal plans or dietary restrictions.

Please list any allergies.

Please describe any limitations or restrictions on RMSC activities.

Please provide any additional information about the participant's behavior and physical, emotional, or mental health about which the camp should be aware.

Please complete all four (4) pages.

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Physician Information & Signature

Name (please print):_____

Address:_____

City:_____ State:_____ Zip Code:_____

Phone:_____

Signature:_____ Date:_____

MEDICAL RELEASE FORM

I/We hereby give permission to Rocky Mountain Summer Conservatory to seek medical care for my/our child, in the event of illness or injury for the period of the program.

Signature _____ *Date* _____

(Parent/Legal Guardian)

PHYSICIAN INFORMATION

Please provide the following information:

Physician:

Physician's Phone Number:

***Insurance Company:**

Insurance Company phone:

Insurance Policy Number:

RMSC will request a copy of your insurance card if you do not attach it to this document. Please have a copy available at check-in.

Additional Billing Information: