MEDICAL RELEASE AND PHYSICAL EXAMINATION

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.
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:

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Dates: Mo/Yr Mo/Yr Mo/Yr Mo/Yr Mo/Yr Mo/Yr</th>
</tr>
</thead>
<tbody>
<tr>
<td>DTP</td>
<td>___ ___ ___ ___ ___ ___</td>
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<tr>
<td>TD</td>
<td>___ ___ ___ ___ ___ ___</td>
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<tr>
<td>Tetanus</td>
<td>___ ___ ___ ___ ___ ___</td>
</tr>
<tr>
<td>Polio</td>
<td>___ ___ ___ ___ ___ ___</td>
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<tr>
<td>MMR</td>
<td>___ ___ ___ ___ ___ ___</td>
</tr>
<tr>
<td>or Measles</td>
<td>___ ___ ___ ___ ___ ___</td>
</tr>
<tr>
<td>or Mumps</td>
<td>___ ___ ___ ___ ___ ___</td>
</tr>
<tr>
<td>or Rubella</td>
<td>___ ___ ___ ___ ___ ___</td>
</tr>
<tr>
<td>Haemophilus influenza B</td>
<td>___ ___ ___ ___</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>___ ___ ___ ___ ___ ___</td>
</tr>
<tr>
<td>Varicella (chicken pox)</td>
<td>___ ___ ___</td>
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<tr>
<td>BGG</td>
<td>___ ___ ___ ___ ___ ___</td>
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</tbody>
</table>

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:
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.*
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:

Please complete all four (4) pages.