UNIVERSITY OF NORTH TEXAS

YOUTH CAMP MEDICAL INFORMATION AND RELEASE FORM

The Medical Information and Release form will be kept onsite with Camp Staff for the duration of the camp. This form requests basic medical history information and authorizes UNT to obtain medical treatment for the camp participant if necessary.

DATE: _____ **SOCIAL SECURITY NUMBER:** _____ - _____ - _____

NAME OF YOUTH CAMP: _____

NAME OF CAMP PARTICIPANT: _____

ADDRESS: _____

CITY: _____STATE: _____ZIP: _____

DATE OF BIRTH: _____ SEX: _____ HEIGHT: _____ WEIGHT: _____

PARENT (or guardian) NAME: _____

ADDRESS: _____

CITY: _____STATE: _____ZIP: _____

HOME PHONE: ( ) _____ WORK PHONE: ( ) _____

EMERGENCY CONTACT #1 NAME: _____ RELATION: _____

ADDRESS: _____

CITY: _____STATE: _____ZIP: _____

HOME PHONE: ( ) _____ WORK PHONE: ( ) _____

EMERGENCY CONTACT #2 NAME: _____ RELATION: _____

ADDRESS: _____

CITY: _____STATE: _____ZIP: _____

HOME PHONE: ( ) _____ WORK PHONE: ( ) _____

PRIMARY CARE PHYSICIAN: _____

ADDRESS: _____

CITY: _____STATE:_____ZIP: _____

PHONE: ( ) _____

Health/accident insurance carrier and appropriate policy certificate number:

_____ _____

NAME OF CARRIER POLICY NUMBER

PLEASE ATTACH A COPY OF YOUR INSURANCE CARD.

Does the Camp Participant have any chronic or acute medical problems? YES: _____ NO:_____

Please explain: _____

_____

_____

List any allergies to food, pollen, or medicine: _____

_____

_____

List any medications being taken at present time: _____

_____

_____

List any other conditions we should be aware of: _____

_____

_____

My child has permission to attend a youth camp on the University of North Texas Campus. I fully realize that injury or illness to my child may result from or during participation in the youth camp. In case of injury or illness, I give permission for my child to be given medical treatment as deemed appropriate. I further give permission for the information provided on this form to be shared with appropriate medical personnel. I further give permission for and grant authority to the camp representatives to sign on my behalf the Notice of Privacy Practice that patients are required to receive in accordance with federal law. I understand and acknowledge that I will be responsible for any medical bills incurred by my child at the University of North Texas Student Health and Wellness Center, at a local hospital or elsewhere.

Name of Camp Participant: _____

Social Security Number: _____ - _____ - _____

Name of Parent/Guardian: _____

Signature: _____ **Date:** _____