Medical Release and Information

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: \_\_\_\_ Age:\_\_\_\_ Race:\_\_\_\_

 (Last) (First) (Middle)

PAST MEDICAL HISTORY:

\_\_\_\_ Diabetes \_\_\_\_ Hypertension \_\_\_\_ Cardiac \_\_\_\_ Asthma \_\_\_\_ COPD

\_\_\_\_ Seizures\*\*

\*\* If the camper is subject to seizures, describe type and frequency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last seizure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Where are they most likely to occur? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are camper’s immunizations up-to-date? \_\_\_\_\_ Yes \_\_\_\_\_ No

Has camper had any recent illnesses or hospitalization in the last 5 years? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Can camper take ASPIRIN? \_\_\_\_ Yes \_\_\_\_ No

Can camper take TYLENOL? \_\_\_\_ Yes \_\_\_\_ No

Are there any other significant Medical Problems?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all drug allergies (please include reaction and action to be taken): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other allergies (example: food, insect stings, poison ivy, etc…): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Special Diets:**

If a camper is on a special diet the following guidelines must be followed. First, we ask that you check with us to see what our menu offers and if slight modifications will accommodate your camper. If the special diet must be implemented then all food for all meals must be brought by you for your camper. We are unable to secure most items for special diets due to lack of availability in our area. We will not be responsible for trying to find these items. Items should be selected for their ease in preparation and should be brought in the most completed stage for serving possible.

**Medical Care**

I hereby grant to the nurse, camp medic or authorized representatives to furnish or arrange for the furnishing of such hospital and medical care as \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Name of Camper) might require during such time as he/she is a camper at the Center Ridge Outpost. This medical care shall include, but not be limited to, examinations, treatment, injections, anesthesia, surgery, and other procedures, etc… I understand that I shall be notified as soon as possible. Failure in such efforts shall not prevent the provision of emergency treatment necessary for the best interest of the life and health of said camper.

The nurses, staff and counselors of The Center Ridge Outpost are comprised almost solely of volunteers and/or parents of children diagnosed with autism spectrum disorders. Each is providing their time and services free with no expectation of compensation. Therefore, in the case of an emergency first aid guidelines will be followed and if the need necessitates campers, counselors and/or staff will be transported to the nearest hospital by ambulance or other approved means. Every safety precaution is taken to make each campers camp experience enjoyable and safe.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ the parent/legal guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(camper) understand and agree that my child will receive first aid treatment by camp personnel and if the need necessitates will be transported to an emergency medical facility to receive further treatment. I also understand that I will be notified promptly if such an event occurs. I release The Center Ridge Outpost nurses, counselors, staff and/or Board of Directors of TEAAM of all legal and/or financial responsibilities of events and/or treatment that might occur during camp that may result in injury to my child.

Parent’s Initials \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Center Ridge Outpost

MEDICATION RELEASE

At our Outpost programs, we will be able to provide first aid through our nursing and/or first

responder volunteers. If your camper requires any prescription or over-the-counter (OTC)

medications or special medical treatment please list:

MEDICATIONS: Please list ALL medications\*\*, purpose of drug dosages, times medication is taken:

Name of Medication Purpose of Drug Dosage Times to be Taken

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

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LIST ANY OTHER MEDICATIONS ON A SEPARATE SHEET

\*\*Please Note: Campers are expected to bring sufficient supplies of their medication,

properly identified, with complete directions for their use. The Center Ridge Outpost

will not provide prescription medicine. Please send enough for the camper’s entire stay. Any excess medication will be returned. Medication should be in a mediset or in current prescription bottles.

Allergies (medicine, food, other):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ verify the above information to be current and

Parent or Legal Guardian

accurate. I give permission to The Center Ridge Outpost staff/volunteers to give/assist

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ with his/her medications/medical concerns .

Camper

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent or Legal Guardian’s Signature Camper’s Physician’s Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Date