

PLAYING MY STORY
CAMP
August 2 - 6, 2010

Camp Medical Release Form

Child's Name _____ Male Female

I. General Information

D/O/B: _____ Age: _____ Grade in Fall: _____
Emergency Contact #1: _____ Relationship to Camper: _____
Daytime Phone: _____ Cell Phone: _____
Address: City/State/Zip: _____
Emergency Contact #2: _____ Relationship to Camper: _____
Daytime Phone: _____ Cell Phone: _____
Address: _____ City/State/Zip: _____
Parent Email Address (for camp info/communication only): _____

II. Medical and Dental Practitioner Information

Name of Physician/Clinic: _____
Address: _____
City/State/Zip: _____ Phone Number: _____
Name of Dentist: _____
Address: _____
City/State/Zip: _____ Phone Number: _____
Name of Insurance Co.: _____
Address: _____
Insurance Company Phone Number: _____
Policy Number: Name of Policy Holder: _____

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III. Health History/Medical Information

Does this child have any allergies (including food, medication and environmental) or dietary restrictions?

Please specify: _____

Does this child have any medical problems, any chronic or recurring illness, or special concerns (physical, mental, emotional), which would effect this child's participation in camp activities?

Please explain: _____

Current medications/food supplements/etc: _____

IV. Treatment Authorization

I hereby give the Historical Society of Washington D.C. (HSW) staff permission to administer basic first aid when applicable, including the treatment of minor cuts, scrapes, burns (including sunburns) and stings. Medication will not be administered by HSW staff at any time. Should my child need the medication listed on the attached form, it will be self-administered. I hereby give permission to medical personnel and Emergency Medical Services selected by the staff of the HSW to provide transportation and treatments, including X-rays and routine tests, for my child. In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by HSW staff to secure and administer treatment, including hospitalization and surgery, for my child. The completed forms may be photocopied for trips out of camp. I agree to assume financial responsibility for all medical and hospital expenses.

Parent/Guardian Name (Please Print)

Parent/Guardian Signature Date

V. Confirmation and Release The aforementioned information is correct and the child herein described has permission to engage in all activities in the program, except as noted. On behalf of myself and my child, I agree to release and hold harmless the Historical Society of Washington D.C., its Regents, officers, employees, and volunteers from any and all liability for personal injury, death, property damage, or loss of any kind or nature whatsoever (whether caused by negligence or otherwise), arising directly or indirectly in connection with my child's participation Historical Society of Washington D.C.- sponsored activities, on or off the camp, including any first aid, medical care, surgery, and hospitalization given or withheld from my child.

Parent/Guardian Name (Please Print)

Parent/Guardian Signature Date

THIS FORM MUST BE RECEIVED BEFORE CAMP SESSION BEGINS.

PLEASE MAKE A COPY FOR YOUR RECORDS

ALLOW AT LEAST FIVE DAYS FOR MAIL.

Historical Society of Washington

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Washington DC 20001

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