WINSHAPE CAMPS FOR COMMUNITIES
Camper Medical Information, Authorization and Release Form

(This is a legal document. Please read carefully and complete all sections.)

Camper's Name: _____ Gender: _____ Birthday:_____ Age: _____

Address:_____City: _____ _____ State:_____ Zip: _ _____

Mother's Name: _____

Bus. Phone (_____)_____

Mother's Cell Phone (_____) _____

Father's Name: _____

Bus. Phone (_____)_____

Father's Cell Phone (_____) _____

Alternate Address (if two households):_____

A. PARENTAL / LEGAL GUARDIAN AUTHORIZATION

As the parent/legal guardian of the above listed child (the "Camper"), I have voluntarily enrolled him or her in a Day Camp sponsored by the WinShape Foundation, Inc. and other entities listed below. The Camper has permission to engage in all camp activities except as expressly noted on this form. I will provide accurate and complete information on this form as to the Camper's health history and status, and I understand this information will be relied upon by others during the camp. I understand the information on this form will be transmitted, stored, and used in electronic format and will be accessed and disclosed on a need to know basis. I also understand this information may be shared as necessary and appropriate for the Day Camp, its administration, and operations. I consent to first aid treatment for the Camper and the use of generic and over the counter medications and treatments, as directed by manufacturer labels, to be administered to the Camper by Camp WinShape staff, camp personnel and/or camp volunteers (collectively "Camp Staff") and first aid personnel. I also authorize Camp Staff and first aid personnel to arrange for transportation of the Camper to a health care provider or facility as deemed necessary and appropriate in their discretion. I understand Camp Staff will make a good faith effort to contact the above named parents or guardians before seeking treatment of serious health conditions. If this is not possible, I understand the Camp Staff will notify parents/legal guardians as soon as practical. In the event a parent or legal guardian cannot be reached in an emergency, I hereby authorize the Camp Director or his/her designee to act as an agent for me to consent to any examination, testing, x-rays, medical, dental or surgical treatment for the Camper as advised by a licensed physician, dentist or other health care provider. This includes, but is not limited to, assessment, evaluation, medical care, anesthesia, hospitalization, or other health care treatment or procedure. I give permission for health care providers treating the Camper to discuss the Camper's health status, diagnosis and test results with the Camp Director or his /her designee, as my agent. I understand that I am and remain responsible for payment of such hospital, physician, ambulance, dental, medical or other services obtained for the Camper. If I have health insurance, I understand my personal health insurance is primary coverage. Copies of this signed form are as valid as an original.

I understand all prescription medication for the Camper must be sent in the original container received from the pharmacy as labeled with the Camper's name and instructions for use. Camp Staff and first aid personnel are authorized to administer such prescription medication to the Camper. I understand the Camper should not attend Day Camp if he or she is sick or has a temperature over 100 degrees.

B. RELEASE AND INDEMNIFICATION

On behalf of myself and also the Camper's other parent or legal guardian, on whose behalf I am fully authorized to sign, I hereby release and indemnify WinShape Foundation, Inc., WinShape Camps for Communities, Connect Ministries, Inc., the _____ Church (which is the host church for the Day Camp) and each of their owners, shareholders, officers, directors, managers, employees, affiliates, sponsors, and agents from any and all claims, liabilities, demands, damages and causes of action resulting or arising, directly or indirectly, from any action taken by any of them pursuant to this Camper Medical Information, Authorization and Release Form.

Parent/Guardian Signature _____ **Printed Name**_____

FOR FLORIDA RESIDENTS ONLY: *Signature must be witnessed by a Notary Public*

Sworn to and subscribed before me this day of _____, 20_____.

State of Florida
County of _____ Notary Public_____ My Commission Expires: _____
(NOTARIAL SEAL)

C. EMERGENCY CONTACT: If neither parent/guardian can be reached in an emergency, please notify:

1. Name: _____ Home Phone: (____)_____ Business Phone: (____) _____
   Relationship to Camper: _____ Cell Phone: (____) _____

2. Name: _____ Home Phone: (____)_____ Business Phone: (____) _____
   Relationship to Camper: _____ Cell Phone: (____) _____

D. INSURANCE INFORMATION

Please attach a copy of your insurance card (front and back)

Insurance Company: _____ Name of Policy Holder: _____

Policy Number: _____ Group Number: _____ ID Number: _____

Address or phone number for claims: _____

E. HEALTH HISTORY: Does camper have a history of any of the following: (If yes, please provide additional information below.)

Hospitalization?	☐ Yes	☐ No	Back or joint problems?	☐ Yes	☐ No	Diabetes?	☐ Yes	☐ No
Surgery?	☐ Yes	☐ No	Seizures?	☐ Yes	☐ No	Skin issues/problems?	☐ Yes	☐ No
Repeating/chronic illness?	☐ Yes	☐ No	Frequent headaches?	☐ Yes	☐ No	If female, have problems with periods or		
Recent infectious disease?	☐ Yes	☐ No	Had Chicken Pox?	☐ Yes	☐ No	menstruation?	☐ Yes	☐ No
Recent injury?	☐ Yes	☐ No	Allergic to Penicillin?	☐ Yes	☐ No	Had mononucleosis (also called mono)?		
Shortness of breath,			Allergic to other drugs?	☐ Yes	☐ No		☐ Yes	☐ No
wheezing or asthma?	☐ Yes	☐ No	Any other allergies			Exposure to infectious or		
Fainting or dizziness?	☐ Yes	☐ No	(including food)?	☐ Yes	☐ No	communicable disease?	☐ Yes	☐ No
Behavior or			Bringing Epi Pen?	☐ Yes	☐ No	Glasses, contacts,		
emotional concerns?	☐ Yes	☐ No	Severe reaction to stings?	☐ Yes	☐ No	or protective eyewear?	☐ Yes	☐ No
ADD/ADHD?	☐ Yes	☐ No	Any diet restrictions?	☐ Yes	☐ No	**Traveled outside the U.S**		
Eating disorders?	☐ Yes	☐ No	Diarrhea or			**in the past year?**	☐ Yes	☐ No
			constipation problems?	☐ Yes	☐ No			

Please list any details related to any "yes" answers, plus special instructions and Camp activity restrictions (for travel outside US, please list names of countries and travel dates): _____

_____

Any major event which affected camper in last 12 months (death of family member/close friend, natural disaster, trauma/abuse, new sibling, other)?

_____

Please list all prescription medications taken by Camper at any point during the 12 months prior to camp: _____

_____

List any medications to be taken by Camper during camp, including drug, dosage, method (oral, inhaler, injection, etc.), and frequency: _____

_____