



Medical Release Form

Full Name: _____ Date of
Birth: _____
Permanent
Address: _____
City: _____ State: _____ Zip: _____ Apt
#: _____
SSN: _____ Sex: _____ Age: _____
Emergency Contact: _____ Phone
#: _____
Relationship: _____ Cell
#: _____
Insurance Company: _____ Policy
#: _____
Member Name: _____

Medical Information:

Allergies (If none, say
so): _____
Medication Taken on Daily
Basis: _____
List any Health
Conditions: _____
Date of Last Tetanus Shot: ___ / ___ / ___

Name: _____ has my permission to participate in all activities while in attendance at Camp Barnabas. I realize that Camp Barnabas does not have medical personnel on site to provide care to the participants and I therefore give permission to the Group Leader to select a facility to provide care to myself or my child in case of an injury or illness. I give the Group Leader permission to select a physician, approve the use of medication, X-rays, anesthesia and/or hospitalize my child in case I cannot be reached by telephone. I realize every effort will be made to reach me by telephone prior to administering non-emergency care to my child. However, if medical care is deemed necessary and the parent cannot be reached, I give permission to the group leader to act on my behalf and select the

medical personnel necessary to provide care for my child. I have provided the following telephone numbers where I can be reached to discuss the care or medical needs of my child.

List any medical or food allergies: _____

To the best of my knowledge, the information given on the Medical Release Form is Accurate.

Signature: _____ Date: _____

(Parent or Legal Guardian must sign if under 18)