SHINE CATHOLIC WORK CAMP
MEDICAL INFORMATION & RELEASE

(MUST BE COMPLETED BY EVERY PARTICIPANT)
-PLEASE RETURN TO YOUTH GROUP CONTACT PERSON-

PLEASE PRINT NEATLY

Church:___________________________________ Contact Person: _____________________________________

Name:____ ❑ Male ❑ Female Age:__________

Address:____

City:_____________________________________ State:_________________ Zip:_________________________

Home phone (______) _______________________________ Parent cell phone (_____)____________________

Emergency Contact: _______________________________________ Relationship: ______________________

Phone (______) _____________________________ Other phone (_______) ______________________________

HEALTH STATUS (confidential)
Please list any/all health problems you may have (ex. Asthma, Allergies, Hay Fever, Hearing difficulties, Back trouble, Diabetes, Seizures, etc.)

____

Date of last tetanus shot:______________Social Security # (for emergency room use) _______________________

Please list any/all medication(s) you are taking: ____

____
(NOTE: All medications need to be in the care of adult leader during the camp.) UPDATE MEDICATION INFORMATION PRIOR TO DEPARTURE TO REFLECT CHANGES

Please list any medication(s) that participant is allergic to:____

____

Personal Medical Insurance Provider:____

Name of Policy Holder: _____________________________________ Ins. Policy # _______________________

**PLEASE ATTACH COPY OF MEDICAL INSURANCE CARD (FRONT & BACK)

EMERGENCY MEDICAL RELEASE

In the event of an emergency, or should medical needs arise, I hereby give permission to SHINE Catholic Work Camp, its staff, volunteers, or representatives to transport me/my child to a doctor or hospital and hereby authorize medical treatment as needed. I release SHINE Catholic Work Camp of all responsibility and consequences resulting from such treatment. Furthermore, I agree to and accept any and all financial responsibility as a result of medical treatment.

____ _______________________________
(Participant's Signature) (Date)

____ _______________________________
(Custodial Parent Signature – if under 18 years of age) (Emergency Phone #)

PLEASE NOTE: We cannot allow anyone without personal medical insurance coverage to participate in SHINE Catholic Work Camp. If special diets are needed, we are not responsible, but are willing to with assist those as much as possible. ANYONE WHO ARRIVES AT WORK CAMP WITHOUT THE PROPER SIGNATURE OR AN INCOMPLETE FORM, WILL BE NOT BE ALLOWED TO PARTICIPATE IN THE WORK CAMP. PARENT AND PARTICIPANT SIGNATURE(S) ARE REQUIRED ON MEDICAL FORM AND RELEASE OF CLAIMS.