



2019 Camp Artemis Medical Release

Mail completed form to:
Camp Artemis, P.O. Box 1053, Greenfield, Ca 93927



PART I: PARTICIPANT INFORMATION

Name: _____ Date of Birth: _____ Age: _____
Address: _____ City: _____ Zip: _____
Parent/Guardian 1: _____ Phone: () _____ Work: () _____
Parent/Guardian 2: _____ Phone: () _____ Work: () _____

PART II: IMMUNIZATION HISTORY

- ☐ I attest that all immunizations for school are current.
☐ NOT immunized. *Immunization is not mandatory. We respect the rights of parents to elect or decline immunization for their child. However, should we be notified of a possible exposure or threat of exposure to illnesses which are customarily immunized, as a safety precaution, you will be notified, and your child will not be allowed to attend camp.*

PART III: RECORD OF HEALTH EXAMINATION

To be completed WITHIN 12 MONTHS of camp attendance by: a Licensed Physician (MD), Physician's Assistant (PA) or Nurse Practitioner (NP) acting under the supervision of a licensed MD.

The examination date for the above participant must be dated after August 1, 2018.

Exam Date: _____ Height: _____ ft _____ inches _____ lbs. Blood Pressure: _____ / _____

The participant is under care for the following condition(s): _____

ALLERGIES:

Describe what the camper is allergic to and the reaction.

<input type="checkbox"/> To Foods (list):	
<input type="checkbox"/> To medications (list):	
<input type="checkbox"/> To the environment (insect stings, hay fever, etc. list):	
<input type="checkbox"/> Other allergies (list):	

DIET:

Describe dietary needs.

<input type="checkbox"/> This camper eats a vegetarian diet	
<input type="checkbox"/> This camper has special food needs.	

Does the camper take any prescribed medication(s)? ☐ No ☐ Yes Are either of the following prescribed? ☐ Inhaler ☐ EpiPen

Medication Name	Dosage	To Administer At *	Reason for taking
		<input type="checkbox"/> B <input type="checkbox"/> L <input type="checkbox"/> D <input type="checkbox"/> Bed <input type="checkbox"/> As needed	
		<input type="checkbox"/> B <input type="checkbox"/> L <input type="checkbox"/> D <input type="checkbox"/> Bed <input type="checkbox"/> As needed	
		<input type="checkbox"/> B <input type="checkbox"/> L <input type="checkbox"/> D <input type="checkbox"/> Bed <input type="checkbox"/> As needed	
		<input type="checkbox"/> B <input type="checkbox"/> L <input type="checkbox"/> D <input type="checkbox"/> Bed <input type="checkbox"/> As needed	

*B: Breakfast 8-9 a.m., L: Lunch noon-1 p.m., D: Dinner 6-7 p.m., Bed: Bedtime 8-10 p.m.

I have reviewed the Camper Health History Form and have discussed the camp program with the camper and their parent/guardian. It is my opinion that the camper is physically and emotionally fit to participate in an active camp program which will include backpacking, camping, swimming and archery.

Medical Office Stamp

Signature of Physician

Date Signed