Pitcairn Camp "G" 2019 MEDICAL & PHYSICAL FORM

NAME: _____

FIRST MIDDLE LAST

PARENT/GUARDIAN-Please answer the following questions.

Is your child in good health? YES or NO

ALLERGIES: Does your child have allergies? YES or NO

ALLERGY: _____ **REACTION:** _____
ALLERGY: _____ **REACTION:** _____
ALLERGY: _____ **REACTION:** _____

Does your child suffer from? (Please Circle)

Diabetes **Heart Disease** **Cancer** **Seizure Disorder** **Asthma**

Stomach Problems **Mental Disorder** **Social Disorder** **Pulmonary Disorder**

If you circled any of the above, please give a brief explanation to include your child's diagnosis, medication and any special needs while at camp:

_____

_____

_____

_____

Is your child at a high risk for any of the following? (Please Circle)

Sunburn **Poison Ivy/Oak** **Sore Throat** **Stomach Cramps**

Homesickness **Bedwetting**

Does your child have any physical or sensory limitations? (Please Circle)

Poor Eye Sight **Sprain, Strain or fracture to any extremities**

Hearing Loss **Other:** _____

MEDICATION:

Will your child need to take medications while attending camp? YES or NO
(If yes, please have the physician list them on the physical examination page.)

Please list any condition that will limit your child from participating in any activity while at camp:

_____

_____

_____

Pitcairn Camp "G" **PHYSICAL EXAMINATION**

NAME: _____

MUST BE COMPLETED BY A CERTIFIED PHYSICIAN ONLY!

The child listed above will be attending a weeklong camp consisting of physical activities (swimming, sports, etc.) Please give this child a physical examination. List any abnormalities or special needs that the camp medical staff should be made aware of to provide proper care and treatment.

HEIGHT: _____ **WEIGHT:** _____ **BLOOD PRESSURE:** _____

CIRCLE IF ABNORMAL:

Growth Development	**Ears**	**Nose**	**Neck**
Muscular Skeletal	**Teeth**	**Tonsils**	**Skin**
Thyroid	**Lungs**	**Head**	**Eyes**
Genitalia	**G.I.**	**Glands**	**Hernia**

Other: _____

Explanation of abnormality: _____

_____

_____

Diet or Activity Restrictions: _____

_____

_____

MEDICATIONS

NAME	DOSAGE	FREQUENCY
_____	_____	_____
_____	_____	_____
_____	_____	_____

Physician's Signature x_____ **Date:** _____

Physician's Name: _____

Address: _____

Telephone #: _____

Pitcairn Camp "G"

INSURANCE WAIVER

I/We hereby certify that I/we know of Pitcairn Camp "G", and it's camping program, activities, and day trips from camp. I/We hereby agree to permit my / our child:

_____

to attend camp under the supervision of the Pitcairn Camp "G staff & Jr. staff.

I/We are aware that there are some inherent risks involved with the participation in camp activities and permit my/our child to participate in those activities with full understanding of these risks, i.e. falling down while running, etc.

I/We intend to be legally bound and hereby agree to release and hold harmless Pitcairn Camp "G", its officers and members in their official capacity and as individuals from any and all claims, lawsuits and medical costs arising out of injury or illness to my/our child. I/We hereby agree to release and hold harmless any staff member as an individual that may administer "first aid" to my/our child.

I/We currently have in force, and will continue to maintain throughout the camp week an adequate medical insurance policy to cover my/ our child in the event of injury or illness. I hereby agree to submit any injury or illness medical claim of my/our child to my/our insurance provider listed below. I/We hereby agree to assume any deductible and all costs pertaining to this injury or illness from this medical insurance co. I/We hereby agree to assume the cost of medication purchased on behalf of my/our child.

If I/we are unable to be immediately notified of my/our child needing emergency medical treatment during the camp week, I/we hereby intending to be legally bound to permit my/our child to be transported to the hospital, allow the hospital to render such medical treatment necessary to include admission, medication, surgery, anesthesia, etc. This medical treatment will however be with the consent of a doctor at the hospital.

MEDICAL INSURANCE CO._____

MEDICAL INS. CO. ADDRESS_____

MEDICAL INS. CO. TELEPHONE _____

GROUP NO._____

I.D. NO._____

SOCIAL SECURITY NO._____

MOTHER'S SIGNATURE_____ **DATE:** ____/____/____

FATHER'S SIGNATURE_____ **DATE:** ____/____/____

GUARDIAN'S SIGNATURE_____**DATE:**____/____/____