CAMPER'S NAME:

_____

DC Interactive Camps

HEALTH & RELEASE FORM

BRING THIS FORM WITH YOU TO CAMP

(You will not be admitted to camp without this form, completed and signed on both sides!)

CAMP BASE LOCATION _____ CAMP DATES _____

- ☐ June 19-June 30, 2017
- ☐ July 3-July 14, 2017 (Camp Closed on 4th of July)
- ☐ July 17-July 28, 2017
- ☐ July 31-August 11, 2017

Sex: _____ Birthday: _____ Age:_____ Weight: _____

Height:_____ Address _____

City _____ State _____ Zip _____ Home Phone (_____) _____

Work Phone (_____)_____ E-Mail_____

My Phone Number while named camper is at camp (if different from above) (_____) _____

Person to contact in the event I cannot be reached _____

Relation: _____

Phone number of emergency contact person (_____)_____

HEALTH & GENERAL HISTORY:

If the camper should be restricted from any activity please note:_

_____

_____

If the camper will be taking medication during camp, please indicate name of drug and dosage:

_____

Please identify any medical condition or medical history that would require special attention:

_____

I hereby certify that the named camper is in good health and fully able to participate in all activities of the Interactive Camp and that I know of no restrictions, physical impairments, or any other facts, which in any manner limit his/her participation in such a program:

Dated:_____

Parent or Guardian:_____

Please circle those illnesses or conditions that the camper has had:
German Measles Measles Mumps Asthma Chicken Pox Pneumonia Diabetes High Blood Pressure

Physician'sName:_____
Telephone(_____)_____

HEALTH INSURANCE INFORMATION

IMMUNIZATIONS		**ALLERGIES**		**DRUG REACTIONS**	
TYPE	**DATE**	**TYPE**	**YES/NO**	**TYPE**	**YES/NO**
Tetanus Toxoid		Hay Fever		Sulpha	
Polio Vaccine		Asthma		Penicillin	
Tuberculin Test		Eczema		Antibiotics (Type)	
Measles		Insect Stings		Aspirin	
Rubella		Nuts		Other	
Mumps		Other		Other	

Carrier Name: _____

Policy Holder Name:_____

Policy Number: _____

Policy Holder Date of Birth: _____

emergency

I, the parent (guardian) of _____ , give permission for the named camper to receive medical or surgical treatment and hospitalization if necessary. I understand that every attempt will be made to contact me, or the emergency contact named above, before taking this action. I will be financially responsible for any medical attention needed during camp or resulting from an injury received at camp.

☐ **Please initial this box if you do not want your child to receive over-the-counter medications. medical insurance shall be the insurance coverage for any medical I agree that my child can receive over-the-counter remedies. (Tylenol, Sudafed, etc.) treatment.**

I HAVE READ THE POLICIES AND FULLY UNDERSTAND MY OBLIGATIONS STATED THEREIN AND ALSO THE RIGHTS OF COME UNITY INC, DBA LEAD THE SEED FORMED UNDER THE LAWS OF THE STATE OF MARYLAND AND HERBY AGREE TO ACT IN ACCORDANCE. I further grant Lead the Seed and its employees the right to photograph or video my dependent and use the photo and/or other digital reproduction of him/her or other reproduction of his/her physical likeness for publication processes, whether electronic, print, digital or electronic publishing via the Internet. I also agree that my child may be transported by bus and/or camp vehicle to an off-site gymnasium or for emergency medical treatment.

The undersigned further expressly agrees that the attached waiver and assumption of risks agreement is intended to be as broad and inclusive as is permitted by law and that if any portion thereof is held invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect.

Dated:_____Parent or Guardian: _____