



# 2011 RETREAT CAMPER HEALTH FORM

## PERSONAL INFORMATION

Camper's Last Name (Printed)		Camper's First Name (Printed)			M.I.
Street Address		Date of Birth (Month, Day, Year)			Age
City	State	Zip	Height	Weight (Lbs)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female

## IMMUNIZATION RECORDS

If there are any religious or personal objections that do not allow your child to receive immunizations, you must sign a written statement below that you object to immunization, but certify that your child is in good health.

I have religious/personal objections, and my child is in good health. \_\_\_\_\_  
Signature Date

Are your child's immunizations up to date?  Yes  No If no, please explain \_\_\_\_\_

## MEDICATIONS/HEALTH HISTORY

Check if these apply to your child. If necessary, attach an additional page to describe health history in detail.

### MEDICAL CONDITIONS:

- Asthma
- Cardiac Issues/Hypertension
- Diabetes
- Epilepsy
- OTHER \_\_\_\_\_

### ALLERGIES:

- No known non-drug allergies
- Insect/bee/wasp stings
- Nuts:  Mild  Moderate  Severe
- Fish/Shell Fish  Eggs  Milk
- Other (non-drug): \_\_\_\_\_

(if your child has a severe food allergy please contact our dining services at 231-836-1047 to make arrangements.)

### MEDICATION ALLERGIES:

- No known medication allergies
- Has medication allergies (List all medication names & describe reactions): \_\_\_\_\_

Precautions to be observed: \_\_\_\_\_

Operations or injuries: \_\_\_\_\_

### MEDICATIONS:

Drug \_\_\_\_\_ Purpose \_\_\_\_\_ Dosage \_\_\_\_\_

Drug \_\_\_\_\_ Purpose \_\_\_\_\_ Dosage \_\_\_\_\_

## INSURANCE INFORMATION

In the event of accident or illness, parents are completely responsible for any necessary treatment costs incurred.

List all personal insurance information or include a copy of insurance card(s).

Please mark "none" if your child is not covered by health insurance.  None

Carrier or plan name	Carrier Address	Policy holder ID#	Name of policy holder
Group policy number		Carrier telephone	Relationship to camper

## EMERGENCY CONTACT INFORMATION

Mother/Guardian name	Mother/Guardian home phone	Mother/Guardian cell phone
Father/Guardian name	Father/Guardian home phone	Father/Guardian cell phone
Family physician name	Family physician phone	Family physician city
Emergency contact name	Emergency contact phone	Relationship to camper

I. LIMITED PURPOSE POWER OF ATTORNEY: CONSENT TO TREATMENT OF A MINOR

A. The undersigned hereby appoint: \_\_\_\_\_ (Your Group Leader),  
and \_\_\_\_\_ (Your Group Leader)

Craig Soderdahl (SpringHill IN Director), Carey Edgren (SpringHill Program Director), or Keith Rudge (SpringHill Operations Director) each to act alone, and delegate to each such person the power to consent on our behalf to all emergency treatment and/or medical care (except elective surgery) of \_\_\_\_\_ (Child's Name) determined to be necessary or desirable by the child's attending physician at the hospital. This consent does not impose a duty upon SpringHill or its representatives, to provide such assistance, transportation, or services. This Limited Purpose Medical Power of Attorney shall continue until revoked by the undersigned or for (thirteen) 15 months after its date, whichever is earlier. Physicians or the hospital's medical staff may assume and rely that this authorization is currently in effect during such thirteen month period unless notified. I also authorize SpringHill, or representative, as Medical Power of Attorney to have medical information disclosed to the representative of their choice. This is in compliance with HIPPA Privacy Rules which defines a Required Disclosure as "A covered entity must disclose protected health information to individuals (or their personal representatives) specifically when they request access to, or an accounting of disclosures of, their protected health information"

B. This Power of Attorney shall continue until revoked by the undersigned, or for six (6) months after its date, whichever is earlier. Physicians or the hospital's medical staff may assume and rely that this authorization is currently in effect during such six month period unless notified.

II. LIABILITY WAIVER

I recognize that certain hazards and dangers are inherent in the SpringHill events and programs and particularly, but not limited to, the activities of horseback riding, swimming, high adventure areas, paintball, extreme sports, winter tubing, snowboarding, ice skating, and cross-country skiing, and I acknowledge that although SpringHill has taken safety measures to minimize the risk of injury to participants, SpringHill cannot insure nor guarantee that the participants, equipment, premises, and/or activities will be free from hazards, accidents, and/or injuries. I further recognize and have instructed my child in the importance of knowing and abiding by the camp's rules, regulations, and procedures for the safety of activity participants.

In consideration of SpringHill accepting and permitting my child to attend camp and participate in the camp's high adventure activities, I agree that SpringHill, a non-profit corporation, its agents, officers, employees, trustees and volunteers will not be liable for any injury, death, damage and/or loss to my child, and/or anyone claiming on my child's behalf, and I further agree to hold harmless, indemnify and defend SpringHill, its officers, agents, employees, trustees and volunteers for and from any and all damage during the time of my child's attendance and participation at SpringHill, whether such injury, illness, or damage occurs on or off the camp's premises.

III. PHOTO RELEASE

I certify that photographs or videotape pictures of my child participating in the SpringHill programs may be reproduced and utilized in promotional materials for the camp.

DATED: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

Father: \_\_\_\_\_ Home Phone ( \_\_\_\_\_ ) \_\_\_\_\_  
Name

\_\_\_\_\_ Cell Phone ( \_\_\_\_\_ ) \_\_\_\_\_  
Address

\_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ County \_\_\_\_\_

\_\_\_\_\_ Email \_\_\_\_\_ Employer \_\_\_\_\_

Mother: \_\_\_\_\_ Home Phone ( \_\_\_\_\_ ) \_\_\_\_\_  
Name

\_\_\_\_\_ Cell Phone ( \_\_\_\_\_ ) \_\_\_\_\_  
Address

\_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ County \_\_\_\_\_

\_\_\_\_\_ Email \_\_\_\_\_ Employer \_\_\_\_\_

I represent that I am the parent or legal guardian of \_\_\_\_\_ (child's name), that I am at least eighteen (18) years of age and I am under no mental or legal disability which would prevent me from signing and executing this agreement. I further represent that I have read (or have had read to me) and understood the terms of this agreement.

\_\_\_\_\_  
Father/ Guardian Signature Date Mother/Guardian Signature Date

\_\_\_\_\_  
Witness Signature Date Witness Address Witness City State Zip  
(Signature must be witnessed by a person over 18 yrs old, other than your immediate family)