Adopteen Camp-Conference/Midpoint Medical Release

Emergency Contact Information

Name of contact: _____
Phone: _____ (work/home/cell/fax) Relation: _____

Name of contact: _____
Phone: _____ (work/home/cell/fax) Relation: _____

Name of contact: _____
Phone: _____ (work/home/cell/fax) Relation: _____

Name of Physician: _____ Phone: _____
Hospital: _____ Phone: _____
Insurance: _____ Phone: _____

Release:

In the event that we are unable to reach any of the above individuals, please complete the following:

I (and my parent/guardian(s), if I am under 18) hereby authorize any representative of Adopteen/CCAI to take me to the above named physician or medical facility **or the closest medical facility** for medical treatment. I/we will assume all financial liability to the medical care provided.

Participant's Signature: _____ Date: _____

Parent/Guardian(s) Signature: _____ Date: _____

Consent for Medical Treatment

I (and my parent/guardian(s) if I am under 18), _____, authorize the Adopteen director or director's designee to obtain emergency medical treatment for my Camper during the Camp-Conference. I/we consent to an x-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care to be rendered to the Camper at a recognized medical facility, under the general or special supervision of a qualified physician or surgeon. I/we acknowledge that no guarantees have been made to me/us as to the effect of such examinations or treatment on the condition of my/our Camper and that I/we am/are responsible for all reasonable charges in connection with the care and treatment rendered to my/our Camper during this period.

I/we certify that I/we have read and understand the Medical Release Form, that all responses made on this Medical Release Form are true and accurate, and that I/we will notify Adopteen hereafter of any relevant changes in the Camper's health that occur prior to the start of the program.

Participant's Signature: _____ Date: _____

Parent/Guardian's Signature: _____ Date: _____

Parent/Guardian's Signature: _____ Date: _____

Medical Information:

Participant's Full Name: _____

Date of Birth: ____/____/____ Date of last Tetanus Booster: ____/____/____

Known allergies, including medical allergies: _____

Current Medications: _____

Have you ever had or do you now have (check yes or no):

	Yes	No		Yes	No
Chicken Pox			Kidney Problems		
Hepatitis			Chronic Skin Problems		
Tuberculosis			Epilepsy		
Malaria			Fainting Spells		
Heart Disease			Diabetes		
High Blood Pressure			Anemia		
Chronic Chest Pain			Severe Anxiety		
Asthma			Surgery		
Chronic Gastrointestinal Problems			Other		

*Please give details about any items on which you checked "Yes": _____

_____

_____

_____

Any other medical problems you wish to note: _____

_____

_____

Have you been in good health for the past twelve months?	Yes	No
Do you have any significant chronic medical conditions requiring on-going medical supervision and treatment, or have you in the past had any significant condition which is currently in remission?	Yes	No
Are you currently receiving, or have you received in the past two years, counseling for any emotional problem, drug addiction, alcoholism, psychiatric condition, or eating disorder?	Yes	No

*Please elaborate below if you checked yes to any: _____

_____

_____

_____