

IN CONSIDERATION of being permitted to utilize the facilities, services and programs of the YMCA for any purpose, including, but not limited to observation or use of facilities, or equipment, or participation in any off-site program affiliated with the YMCA, the undersigned, for himself or herself, or on behalf of a minor child under age 18, and for any personal representatives, heirs and next of kin, hereby acknowledges, agrees and represents that he or she has, inspected and carefully considered, or will immediately upon entering and/or participating, inspect and carefully consider, such premises and facilities or the affiliated program. It is further warranted that such entry into the YMCA constitutes an acknowledgement that the undersigned finds and accepts same as being safe and reasonably suited for the purpose of such observation, use or participation.

IN FURTHER CONSIDERATION OF BEING PERMITTED TO ENTER THE YMCA FOR ANY PURPOSE INCLUDING, BUT NOT LIMITED TO OBSERVATION OR USE OF FACILITIES OR EQUIPMENT, OR PARTICIPATION IN ANY OFF-SITE PROGRAM AFFILIATED WITH THE YMCA, **THE UNDERSIGNED HEREBY AGREES TO THE FOLLOWING ON HIS OR HER BEHALF AND/OR BEHALF OF HIS/HER CHILDREN OR GUESTS** (herein referred to as "the undersigned"):

**MEMBER CONDUCT** I agree to abide by all rules and regulations of the YMCA of Metropolitan Hartford (hereafter "YMCA"), and I understand that failure to act in accordance with the rules may result in expulsion from the YMCA .

**INSURANCE** I understand that the YMCA does not provide any accident or health insurance for its members or participants and it is my responsibility to provide such coverage.

**PROPERTY LOSS** I understand that the YMCA is not responsible for personal property lost, damaged or stolen while using YMCA facilities or participating in YMCA programs.

**ASSUME FULL RESPONSIBILITY** I hereby assume full responsibility for and risk of bodily injury, death or property damage while in, upon, or about the premises of the YMCA and/or while using the premises, or any facilities or equipment thereon or participating in any program affiliated with the YMCA.

**PHOTO/TALENT RELEASE** I hereby irrevocably release, consent and allow the YMCA and its agents to use my photograph, likeness, voice, as it pertains to my participation with the YMCA, in any manner for promotional efforts without expectation of any reimbursement for its use. (My initials here revoke photo/talent release \_\_\_\_\_).

**RELEASEE, WAIVE, DISCHARGES** I hereby release, waive, discharge and covenant not to sue the YMCA, its directors, officers, employees, and agents (hereinafter referred to as "releasees") from all liability to the undersigned, his personal representatives, assigns, heirs, and next of kin for any loss or damages, and any claim or demands therefore on account of injury to the person or loss of property while the undersigned is in, upon, or about the premises or any facilities or equipment therein or participating in any program affiliated with the YMCA.

**INDEMNIFY AND SAVE AND HOLD HARMLESS** I hereby agree to indemnify and save and hold harmless the releasees from any loss, liability, damage or cost they may incur due to the presence of the undersigned in, upon or about the YMCA premises or in any way observing or using any facilities or equipment of the YMCA or participating in any program affiliated with the YMCA.

**MEDICAL RELEASE** I authorize the YMCA, as my agent, to give consent to medical treatment by a licensed physician or hospital when such treatment is deemed necessary by the physician, and I am unable to give such consent. I authorize a qualified YMCA staff member to administer CPR or first aid if necessary. I understand that it may be necessary for me to provide a release form from my physician regarding my current health status.

THE UNDERSIGNED further expressly agrees that the foregoing RELEASE, WAIVER AND INDEMNITY AGREEMENT is intended to be as broad and inclusive as is permitted by the law of the State of Connecticut and that if any portion thereof is held invalid, it is agreed that the balance shall, notwithstanding continue in full legal force and effect.

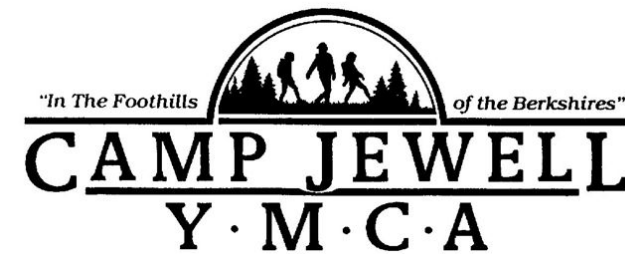
THE UNDERSIGNED HAS READ AND VOLUNTARILY SIGNS THE RELEASE AND WAIVER OF LIABILITY AND INDEMNITY AND PHOTO/TALENT RELEASE AGREEMENT, and further agrees that no oral representations, statement or inducement apart from the foregoing written agreement have been made.

I HAVE READ THIS RELEASE.

**Printed Name of Camper** \_\_\_\_\_

**Signature of parent or guardian** \_\_\_\_\_ **Date** \_\_\_\_\_

Please attach a copy of your camper's health insurance and prescription drug coverage cards to the back of this health form. Please provide copies of both the front and back of the cards. You may tape or staple copies to this back page. If family has no medical insurance, state "none".



# Health Form Parent/Guardian Authorization, Release & Indemnity Waiver

## Camper Information

Camper Name \_\_\_\_\_

Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_ Gender **M / F**

Street \_\_\_\_\_

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

Parent/Guardian 1 \_\_\_\_\_

Home(\_\_\_\_) \_\_\_\_\_ Work(\_\_\_\_) \_\_\_\_\_ Cell(\_\_\_\_) \_\_\_\_\_

Parent/Guardian 2 \_\_\_\_\_

Home(\_\_\_\_) \_\_\_\_\_ Work(\_\_\_\_) \_\_\_\_\_ Cell(\_\_\_\_) \_\_\_\_\_

Emergency Contact \_\_\_\_\_

Home(\_\_\_\_) \_\_\_\_\_ Work(\_\_\_\_) \_\_\_\_\_ Cell(\_\_\_\_) \_\_\_\_\_

**Please indicate if your child has had any of the following injuries, conditions, or illnesses:**

- |   |  |                                      |
|---|--|--------------------------------------|
| <input type="checkbox"/> Asthma         | <input type="checkbox"/> GI Disorders    | <input type="checkbox"/> Psychiatric |
| <input type="checkbox"/> Frequent       | <input type="checkbox"/> Heart Problems  | Diagnosis                            |
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> ADD/ADHD        | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Seizure        | <input type="checkbox"/> Muscular/       |                                      |
| <input type="checkbox"/> Diabetes       | <input type="checkbox"/> Skeletal Injury | _____                                |
|   | <input type="checkbox"/> Sleepwalking    |                                      |

Please record information about any items above; any significant medical history; any hospitalization, doctor visits or surgical history of consequence in the past 5 years; and any other health related information or further suggestions for camp personnel (attach additional information if necessary)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Vegetarian? Yes / No**

**Any Other Dietary Concerns?**

\_\_\_\_\_  
\_\_\_\_\_

**Bring This Form With  
You to Camp on  
Check In Day**

- Please Double Check  
The Following:**
- **Parent/Guardian Signatures Pages 2 & 4**
  - **Doctor's Signature Page 3**
  - **Necessary Medication Authorization Form(s)**
  - **Copy of Insurance Cards Attached (front & back)**

## Allergies

List ALL Known (describe usual reaction and treatment)

Allergy \_\_\_\_\_

Reaction \_\_\_\_\_

Treatment \_\_\_\_\_

**Do Not Mail This Form  
In Advance**

Program(s)

Session(s) at Camp

Camper Name

# This Section to be completed by a Parent/Guardian

To my knowledge, this health history is correct, and the person herein described has permission to engage in all camp activities except as noted.

**Authorization for Treatment:** I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, treatment, and necessary transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for my child as named above. This completed form may be photocopied for trips out of camp. I also give permission for routine medical care as per the camp physician's standing orders for my child at Camp Jewell YMCA. I understand the camp fees do not include health and accident insurance and I will be responsible for any and all charges incurred in obtaining prompt medical attention.

Signature of parent or guardian \_\_\_\_\_ Date \_\_\_\_\_

*If a situation occurs at camp that requires your camper to be seen by a medical professional other than the camp nurses Camp Jewell's nursing staff will attempt to contact the camper's parents.*

During Resident & Day camp programs, the following medications are kept in stock and are used to treat minor symptoms of illness/injury. They are administered by a Registered Nurse or Licensed Practical Nurse according to the Standing Orders of our Camp Physician. Please **CROSS OUT** any medications listed below that you do **NOT** want to be administered.

- |                 |                   |                  |                         |
|-----------------|-------------------|------------------|-------------------------|
| Bacitracin      | Eipen             | Motrin           | Sudafed                 |
| Benadryl        | Eyewash           | Nix Shampoo      | Throat Lozenges         |
| Betadine        | Hydrocortisone    | Natural Tears    | Tums or Antacid Tablets |
| Caladryl        | Hydrogen Peroxide | Oragel           | Tylenol                 |
| Calagel         | Kaopectate        | Pepto Bismol     | Visine                  |
| Calamine Lotion | Lotrimin          | Rid Shampoo      | Zinc Oxide              |
| Claritin        | Maalox            | Robitussin Syrup |                         |

**Medication Authorization :**

I hereby give permission to Camp Jewell YMCA medical personnel to administer any of the above medications or their generic equivalents **not crossed out** per the directions of the Camp Physician.

Signature of parent or guardian \_\_\_\_\_ Date \_\_\_\_\_

**When Bringing Medication to Camp:**

Connecticut State Law now requires an authorized prescriber's (M.D., Dentist, P.A., A.P.R.N.) written order AND parent or guardian's authorization for a nurse or camp personnel with current Medication Administration Training to administer medications brought from home. Prescription medications must be in the pharmacy prepared containers and labeled with the name of the child, name of the drug, strength, dosage, frequency, authorized prescriber's name and date of the original prescription. Over-the-counter medication must be in the original container and labeled with the child's name.

**You MUST have one Medication Authorization Form for EACH prescription or over-the-counter medication you send with your child to camp.**

**A Doctor MUST Sign the Medication Authorization Form even for over-the-counter medications including vitamins and herbal supplements.**

*The Medication Authorization Form is available on our website  
 www.campjewellymca.org on the form downloads page*

Name of Primary Physician \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Name of Dentist/Orthodontist \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

# Immunization History (must be completed by parent or physician's office) You may also attach a copy of your campers' immunization form or a copy of his/her medical/religious vaccination exemption form.

Vaccines	Yes	No	Year of Original Immunization	Year of Last Booster
Chickenpox	_____	_____	_____	_____
Diphtheria	_____	_____	_____	_____
Hepatitis B	_____	_____	_____	_____
Measles	_____	_____	_____	_____
Mumps	_____	_____	_____	_____
Pertussis	_____	_____	_____	_____
Polio	_____	_____	_____	_____
Rubella	_____	_____	_____	_____
Tetanus	_____	_____	_____	_____
HIB-haemophilus influenza b	_____	_____	_____	_____
PCP-Pneumococcal conjugate	_____	_____	_____	_____
Tuberculosis test given: Type _____			Date _____	Result _____

# This Section to be completed by a Licensed Health Care Provider

*Have your health care provider use this form, OR attach his/her own form, OR attach a signed copy of school/camp/or sports physical dated not more than 24 months before your camper's last day at camp.*

I examined the above camp applicant on this date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Month Day Year

**Exam must be within 24 months prior to last day of attendance at camp**

- In my opinion the condition of the camp applicant **ALLOWS** for the participation in an active camp program.
- In my opinion the condition of the camp applicant **DOES NOT ALLOW** for the participation in an active camp program.

**Has the camp applicant been treated for any of the following:**

Yes	No	Condition	Explain
_____	_____	ADHD/ADD	_____
_____	_____	Allergies	_____
_____	_____	Asthma	_____
_____	_____	Bladder Problems/Bedwetting	_____
_____	_____	Bleeding Disorders	_____
_____	_____	Concussion	_____
_____	_____	Dental Braces	_____
_____	_____	Diabetes	_____
_____	_____	Ear/Sinus Problems	_____
_____	_____	Fainting	_____
_____	_____	GI Problems/Constipation	_____
_____	_____	Hearing/Speech Problems	_____
_____	_____	Heart Problems	_____
_____	_____	High Blood Pressure	_____
_____	_____	Learning Disorders	_____
_____	_____	Menstrual Problems	_____
_____	_____	Seizures	_____
_____	_____	Sleeping Problems	_____
_____	_____	Vision Problems / Glasses	_____

**Licensed Health Care Provider's Signature**

Print Name of Health Care Provider \_\_\_\_\_

Health Care Provider's Address \_\_\_\_\_

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

Telephone \_\_\_\_\_

Fax \_\_\_\_\_