

# CAMP CHIEF OURAY/YMCA OF THE ROCKIES

## Parent Release & Medical Examination Form

Camper name : \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Dear Parents,  
 As you know, our camp programs are licensed by the state of Colorado. We are in full compliance with all regulations. The information listed below is required to keep our camp in compliance with these regulations and provide a safe environment for your child. **This form MUST be completed correctly and returned to Camp Chief Ouray for your child to attend camp. \*\* NO EXCEPTIONS\*\***

Parent/Guardian/Staff Authorizations - The person herein described has my express consent to participate in all camp activities, including transportation by bus or mini-bus, except as noted. By giving this consent, I expressly acknowledge that I have been made aware that I/my child may be exposed to the risks of nature and of the elements over which neither the Camp nor its employees have control. Having been informed of such risks, I specifically agree that I/my child may participate in the program. This completed form may be photocopied for trips out of camp. I hereby give permission to the physician selected by the camp director to order X-rays, routine tests, treatment, and emergency transportation for the health of me/my child. I hereby give permission to release the results of any of the aforementioned tests or treatment to Camp Chief Ouray. In the event I cannot be reached in an emergency, I hereby give permission to the physician or medical facility selected by the camp director to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for me/my child as named above. I accept responsibility for medical/surgical treatment charges which may be incurred on my/my child's behalf. I hereby authorize payment directly to the undersigned physician of the surgical and/or medical benefits, if any, otherwise payable to me for his services as described but not to exceed the reasonable and customary charges for those services. I understand that if I have no health insurance, Camp Chief Ouray will provide a limited coverage and that I will be responsible for paying the deductible and any charges which exceed the policy limits. I understand that if I have health insurance, Camp Chief Ouray's limited policy may act as secondary insurance coverage and may cover expenses in excess of the primary insurance policy. I accept responsibility for the cost of any prescriptions and/or related expenses for my/my child's care and understand I will be billed by the camp office.

Signature of parent/guardian (of minors under age of 18) \_\_\_\_\_ Date \_\_\_\_\_

Vaccines		Enter date each immunization was given			
DTP/DTaP	Diphtheria-Pertussis - Tetanus				
Td/DT	Tenanus-Diptheria				
OPV/IPV	Polio				
Hib	Haemophilus influenza type b				Required for children <5 yrs. of age
Measles	Measles			The first MMR must have been given on or after the first birthday. Effective 7/1/2000. The second dose of MMR is required for Kindergarten. Written evidence of laboratory testes showing immunity to measles, mumps, rubella, polio and Hepatitis B is acceptable. Attach written proof to the certificate or record test results and dates in the boxes at left.	
Mumps	Mumps				
Rubella	Rubella				
HB	Hepatitis B				
Varicella	Chickenpox				
Other					
Tuberculin test given _____ (most recent) (STAFF ONLY)					

Please attach a copy of insurance card below:  
 If you're your child does not have health insurance please initial here: \_\_\_\_\_

Front of card

Back of card

**\*\* This page to be completed by a Licensed Physician\*\***

This examination should be performed within 24 months of the date camper will leave camp. Examination for some other purpose within this period is acceptable. Examination is for determining fitness to engage in strenuous activities.

**Camper/Staff Name:** \_\_\_\_\_

**Code:**    **V--Satisfactory**        **X--Not Satisfactory (Explain)**        **O--Not Examined**

**Hgt.** \_\_\_\_\_    **Wt.** \_\_\_\_\_    **B.P.** \_\_\_\_\_

Eyes _____	Hernia _____	Allergy: (Please specify) _____
Glasses _____	Extremities Including: _____	_____
Ears _____	Shoulder _____	_____
Nose _____	Knees _____	General Appraisal: _____
Throat _____	Ankles _____	_____
Heart _____	Feet _____	_____
Genitalia _____	Posture (Spine) _____	_____
Lungs _____	Skin _____	_____
Abdomen _____		

(For Girls and Women)  
 Has this person menstruated? \_\_\_\_\_ If not, has she been told about it? \_\_\_\_\_  
 Is so, is her menstrual history normal? \_\_\_\_\_ Special considerations: \_\_\_\_\_

The camper is under the care of a physician for the following conditions: \_\_\_\_\_

Does camper have epilepsy? Yes \_\_\_ No \_\_\_ Does camper have diabetes? Yes \_\_\_ No \_\_\_

**RECOMMENDATIONS AND RESTRICTIONS WHILE AT CAMP:**

Medically prescribed meal plan or dietary restrictions \_\_\_\_\_  
Any restrictions for:  
 Swimming/Boating \_\_\_\_\_  
 Strenuous Activity \_\_\_\_\_  
 Other \_\_\_\_\_

**CURRENT MEDICATIONS:** Is the camper currently taking any prescribed medications? Yes \_\_\_ No \_\_\_ . Please list all medications currently prescribed for camper. Please use a separate piece of paper for additional prescriptions if necessary.

**\*\* (ALSO INCLUDE ANY OVER THE COUNTER MEDICATIONS TAKEN ON A REGULAR BASIS)\*\***

Name of Medication	Dosage	Is camper bringing to camp? (circle one)
		Yes No
		Yes No
		Yes No
		Yes No
		Yes No

**TO THE EXAMINING PHYSICIAN**

We need your help! Camp Chief Ouray/YMCA of the Rockies is a summer residence camp in Granby, Colorado (elevation 8,750 feet). All campers are required to be physically active (including walking on uneven terrain, strenuous activities during hot weather, hiking at 8,750-10,000 feet elevation). It is important to the safety and well-being of this and other participants that we attain accurate information regarding this person's current medical status and medical history.

**PHYSICIAN'S SIGNATURE REQUIRED**

On the basis of your knowledge of the applicant, the applicant's medical history, the present physical examination of this applicant and your knowledge of the activities in which they will be asked to participate, do you feel this individual is able to participate in the Camp Chief Ouray Program?  
 Yes \_\_\_ No \_\_\_

Name of Physician (Please Print) \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_

Physicians Signature \_\_\_\_\_ Date \_\_\_\_\_