



**YOUTH CAMP MEDICAL INFORMATION AND RELEASE FORM**

The Medical Information and Release form will be kept onsite with Camp Staff for the duration of the camp. This form requests basic medical history information and authorizes UNT to obtain medical treatment for the camp participant if necessary.

DATE: \_\_\_\_\_ SOCIAL SECURITY NUMBER: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

NAME OF YOUTH CAMP: \_\_\_\_\_

NAME OF CAMP PARTICIPANT: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SEX: \_\_\_\_\_ HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_

PARENT (or guardian) NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: ( ) \_\_\_\_\_ WORK PHONE: ( ) \_\_\_\_\_

EMERGENCY CONTACT #1 NAME: \_\_\_\_\_ RELATION: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: ( ) \_\_\_\_\_ WORK PHONE: ( ) \_\_\_\_\_

EMERGENCY CONTACT #2 NAME: \_\_\_\_\_ RELATION: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: ( ) \_\_\_\_\_ WORK PHONE: ( ) \_\_\_\_\_

PRIMARY CARE PHYSICIAN: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE: ( ) \_\_\_\_\_

Health/accident insurance carrier and appropriate policy certificate number:

\_\_\_\_\_  
NAME OF CARRIER

\_\_\_\_\_  
POLICY NUMBER

**PLEASE ATTACH A COPY OF YOUR INSURANCE CARD.**

Does the Camp Participant have any chronic or acute medical problems? YES: \_\_\_\_\_ NO: \_\_\_\_\_

Please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List any allergies to food, pollen, or medicine: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List any medications being taken at present time: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List any other conditions we should be aware of: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

My child has permission to attend a youth camp on the University of North Texas campus. I fully realize that injury or illness to my child may result from or during participation in the youth camp. In case of injury or illness, I give permission for my child to be given medical treatment as deemed appropriate. I further give permission for the information provided on this form to be shared with appropriate medical personnel. I further give permission for and grant authority to the camp representatives to sign on my behalf the Notice of Privacy Practice that patients are required to receive in accordance with federal law. I understand and acknowledge that I will be responsible for any medical bills incurred by my child at the University of North Texas Student Health and Wellness Center, at a local hospital or elsewhere.

**Name of Camp Participant:** \_\_\_\_\_

**Social Security Number:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Name of Parent/Guardian:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_