

**SCHOOL'S OUT SUMMER PROGRAM**  
**HEALTH HISTORY, EMERGENCY CONTACT & RELEASE FORM**  
*To be completed and signed for all campers and CITs.*

(Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Middle) \_\_\_\_\_  
 Camper/ CIT Name \_\_\_\_\_ Gender \_\_\_\_\_

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Grade Entering \_\_\_\_\_

\_\_\_\_\_  
 Street \_\_\_\_\_ City/Town \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Parent/Guardian _____	Parent/Guardian _____
Address _____ (only if different from camper)	Address _____ (only if different from camper)
Phone # _____ Work # _____	Phone # _____ Work # _____
Cell Phone _____	Cell Phone _____
Email _____	Email _____

**Please list below two Emergency Contacts who could pick up a child during camp hours if parent is unavailable. FYI: Parents will always be contacted first in case of an emergency or sickness.**

Emergency Contact _____	Emergency Contact _____
Address _____	Address _____
Phone # _____ Work # _____	Phone # _____ Work # _____
Cell Phone _____	Cell Phone _____

**Insurance Information:**

Insurance Carrier \_\_\_\_\_ Insurance Policy Holder Name \_\_\_\_\_  
 Policy or Group # \_\_\_\_\_

<p><b>Health Concerns/Allergies (Check if yes):</b> Asthma ___ Sunscreen ___ Penicillin ___ Other Drugs _____          Seasonal Allergies ___ Food Allergies ___ Insect Bites &amp; Stings ___ Other _____          Allergy Explanation include the severity of reaction (<i>if touched, if ingested</i>) _____          _____          Medications for Above: (<i>Including: Epi-Pen or Inhaler</i>) _____          List medications child takes AT HOME: _____          Will your child be taking any medications (including over the counter medicine) while AT CAMP? <b>YES</b> or <b>NO</b>          If yes, what medications? _____  <b>All medications must come to camp in the original container with a completed "Medication Administration Consent" form.</b></p>
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**Medication Administration Information:**

Please **CIRCLE** if the following may be applied to your child if needed: Sunscreen Insect Repellent

**Please complete and sign the second page of this form. Completed form required for admission to camp.**

**The School's Out Summer Program is committed to providing a successful camp experience for all who attend. We respect that every individual who participates in our program comes with a unique personal history. Having prior knowledge of any details that may impact your child's experience is invaluable. This may include learning styles, medical conditions, behavioral issues, emotional needs or significant changes that may have impacted their lives. Please do not hesitate to attach additional information or call us with any details.**

Any current physical, mental or psychological conditions requiring medications, treatment or restrictions while at camp? (Such as diabetes, epilepsy, chronic headaches, emotional, behavioral, etc.)

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List any past medical treatment or injuries: \_\_\_\_\_

Camper's current weight: \_\_\_\_\_

Describe any specific activities from which child should be exempted: \_\_\_\_\_

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Any Dietary Modifications/Restrictions: \_\_\_\_\_

Other things you should know: \_\_\_\_\_

**Doctor/Dentist Information:**

Name of family physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Address of family physician: \_\_\_\_\_ Date of Last Physical Exam: \_\_\_\_\_

Name of dentist/orthodontist: \_\_\_\_\_ Phone: \_\_\_\_\_

**The Board of Health requires that we have a copy of your most current (within 18 months) Physician's Certificate of Health and Immunization Record. Immunizations must be age/grade appropriate per Massachusetts School Immunization requirements. PLEASE ATTACH THESE DOCUMENTS TO THIS HEALTH HISTORY FORM AND SUBMIT TOGETHER.**

**Authorization:**

**Accuracy of Information:** This health history is correct and current to the best of my knowledge. The person herein described has permission to engage in all camp activities except as noted.

**Photo Release:** I authorize the School's Out Summer Program permission for our child's photo to appear in promotional literature, videos, session group photos and our website **unless this box is checked** If this box  is checked we will send you an additional form to complete.

**Authorization for Treatment:** In case of health problem or emergency, I authorize the School's Out Summer Program to administer first aid and, where necessary, to transport my child to the nearest hospital emergency room if needed and to order X-rays, routine tests and treatment; and to release any records necessary for insurance purposes. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director, or her designee, to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

**Acknowledgement of Risk & Waiver**

I hereby consent to my child's participation in the School's Out Summer Program. I hereby release and discharge, and agree to indemnify and hold harmless, the School's Out Summer Program and its officers, directors, members, agents, employees, volunteers and any other persons or entities acting on its behalf, against all claims, demands, and causes of action whatsoever, either in law or equity, relating to or arising from personal injuries to my child or property damage resulting from my child's participation in the School's Out Summer Program, as well as any medical treatment, recommendation, transportation or administration, or any lack thereof.

**Signature of Parent/Guardian of Camper or CIT** \_\_\_\_\_

Date: \_\_\_\_\_, 2020