RYLA District 5730 2015/Health History Forms

Page 1 To be filled out by **ALL** attending guests
Page 2 Top portion to be filled out by parent and the bottom portion filled out by a **LICENSED PHYSICIAN** for guests under the age of 18. Forms to be returned by **May 15, 2015** Late forms must be approved by RYLA Director

Program Dates: June 21 through June 25 to be held at South Plains College in Levelland, Texas

Participant Name _____ Date of Birth _____/_____/_____ Age_____ M / F

Parent/Guardian: Father _____ Mother _____

Home address _____City _____ State _____ Zip _____

Email _____ Home # ____ _____

Father's Work # _____ Cell # _____

Mother's Work # _____ Cell # _____

In case of emergency and neither parent can be reached, please notify:

Name _____ Home # _____ Cell # _____

Relationship to camper _____

Family Physician Name _____ Phone # _____

**** PLEASE SEE ATTACHED MEDICAL FORMS ****

If you or your child should require medical attention while at the RYLA conference for injuries received or illnesses contracted prior to coming, please send information necessary to give him/her proper medical service during this time.

In case of emergency, I hereby give permission to the physician selected by the RYLA director or his staff to hospitalize and secure proper treatment for and order injections, anesthesia or surgery for me or my child as named above. I also hereby give my permission for me or my child to participate in all activities, including but not limited to Swimming, Field Sports, Vehicle Transportation, Group Activities and Competitive Games.

If my child needs to leave RYLA before the end of the program I am also responsible for picking up the child or securing and supervising the transportation of my child.

I agree to assume, as an explicit condition of me or my child's/ward's participation, any and all risks, including but not limited to these enumerated above. ***I agree to release, discharge and hold harmless*** *Rotary International, the local Rotary Club sponsoring my child, all counselors, staff and volunteers running the program and South Plains College and its staff from any and all liabilities, claims, demands and causes of action whatsoever which may arise due to the participation of myself or my child/ward.*

I realize, also that in the event of illness or injury while attending RYLA or participating in its activities, medical treatment may be required. I hereby give permission for any such treatment to be rendered, and ***I agree to bear the cost of such treatment****. If any changes occur, I will contact the director in writing.*

Periodically, photographs or videos are taken during RYLA. I acknowledge that by my or my child's participation in RYLA I give permission and consent for any such photographs or videotapes to be shared among participants or on a social media account for RYLA and perhaps used to promote future RYLA programs.

Do you give permission for your child's email address to be shared with other participants after the conclusion of RYLA ***Yes / No (Please circle one).***

_____ / _____ _____ / _____

Father/Guardian Signature Date Mother/Guardian Signature Date

Health History Forms

Page 2 Top portion to be filled out by parent. Bottom portion filled out by a **LICENSED PHYSICIAN** for **ALL** guests under the age of 18. Forms to be returned by **May 15, 2015** for the RYLA program June 21 through June 25, 2015.

Participant Name _____

- ✓ **Attach a photocopy of Shot Record. Date of last Tetanus Shot _____.**
- ✓ **Attach a photocopy of the Front and Back of Insurance Card (essential in emergencies).**
- ✓ **If you do not have Insurance, please call our office to receive an Insurance Disclaimer Form.**

Please list any chronic or recurring illnesses or medical conditions (stomach upsets, rash, frequent cold, etc…), current physical, mental or psychological considerations and **list any allergies** (include food allergies), also list any treatments being taken or given.

RYLA Director may administer the following to my child (check if applicable): _____ Pepto Bismol

_____ Cough Drops ____ Cough Syrup _____ Acetaminophen (Tylenol) _____ Ibuprofen (Motrin) ____ Aspirin (Bayer)

Operations or serious injuries with dates _____

Swimming or Activity Restrictions _____

MEDICATIONS:

- ✓ A Medication Slip is attached and should be used for prescription medication that will be submitted to camp staff at check-in. The top portion is for check-in, the bottom portion should be attached to this registration page.
- ✓ Participants must also submit non-prescription medications and vitamins upon check-in.
- ✓ Certain items such as Inhalers or critical EpiPens may be kept by the camper upon the staff's approval at check-in.

HEALTH CARE RECOMMENDATIONS BY LICENSED PHYSICIAN
A COPY OF A SPORTS PHYSICAL WITHIN THE LAST TWO YEARS WILL BE ACCEPTED

(*) I have examined the above camp applicant within the past 24 months _____ No _____ Yes _____ Date Examined

In my opinion, the applicant is physically able to participate in an active camp program _____ No _____ Yes

List any medically prescribed meal plan or dietary restrictions _____

Current or on-going treatments and/or medications _____

_____

(*) Licensed Physician's Name _____(*) Signature _____

(*) Address _____ (*) City _____ (*) State_____ (*) Zip _____

(*) Phone _____ Date Form Completed _____

Form completed by (If other than Physician) _____

Please complete each line above and note that items with an asterisk (*) are especially important. Thank you!

MEDICATION INFORMATION A – (1) Slip Per Camper

- ✓ Participants to submit medications in a (1) one-gallon clear baggie.
- ✓ (1) bag may contain all medications.
- ✓ Please PRINT information and place this slip in the baggie with the medication **in the prescription container.**
- ✓ Medications cannot be accepted loose or in an unmarked container.
- ✓ Certain items such as Inhalers or critical EpiPens may be kept by the participant upon the staff's approval at check-in. Non-prescription medications, vitamins and scheduled allergy med's should also be submitted.
- ✓ Please indicate if any medication requires refrigeration.

Camper: _____Group: _____
Parent:_____Parent Phone: _____

Medication _____ Dosage: _____
Frequency: MORNING /BREAKFAST / LUNCH / DINNER / BEDTIME Other: _____

Medication _____ Dosage: _____
Frequency: MORNING /BREAKFAST / LUNCH / DINNER / BEDTIME Other: _____

Medication _____ Dosage: _____
Frequency: MORNING /BREAKFAST / LUNCH / DINNER / BEDTIME Other:_____

******* Check-in Use Only Below *******

Counselor: _____ / Dorm: _____ Male /Female

We suggest you make a copy of all forms for your records and cut here for use

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MEDICATION INFORMATION B – (1) Slip Per Camper

- ✓ **Please PRINT information and submit this slip with your registration paperwork SECTION B (PAGE 2).**
- ✓ Medications cannot be accepted loose or in an unmarked container.
- ✓ Certain items such as Inhalers or critical EpiPens may be kept by the camper upon the staff's approval at check-in. Non-prescription medications, vitamins and scheduled allergy med's should also be submitted.
- ✓ Please indicate if any medication requires refrigeration

Camper: _____Group: _____

Parent:_____Parent Phone: _____

Medication _____ Dosage: _____
Frequency: MORNING /BREAKFAST / LUNCH / DINNER / BEDTIME Other: _____

Medication _____ Dosage: _____
Frequency: MORNING /BREAKFAST / LUNCH / DINNER / BEDTIME Other: _____

Medication _____ Dosage: _____
Frequency: MORNING /BREAKFAST / LUNCH / DINNER / BEDTIME Other :_____