

**The Cathedral Domain**  
Camp And Conference Center  
800 Highway 1746, Irvine, Ky 40336-8701

Name of Camp Session \_\_\_\_\_

Date of Camp \_\_\_\_/\_\_\_\_/\_\_\_\_

Return by the following date \_\_\_\_/\_\_\_\_/\_\_\_\_

**Medical Release Form and Permission to Treat**

For Resident Camp Use.

The health history and examination must be updated annually. A licensed medical professional must complete the health examination.

Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Age at camp \_\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Home Address \_\_\_\_\_ Phone # \_\_\_\_\_

Gender of camper (circle) Male Female

Custodial parent/guardian \_\_\_\_\_

Home address \_\_\_\_\_

Business address \_\_\_\_\_

Contact phone numbers (cell, business) \_\_\_\_\_

If not available in emergency, notify \_\_\_\_\_

Relationship to camper \_\_\_\_\_ Phone # \_\_\_\_\_

Insurance information: Is the camper covered by medical/hospital insurance? \_\_\_\_\_

**\*\* Copy front and back of insurance card and attach to this form. \*\***

Family physician \_\_\_\_\_ Phone # \_\_\_\_\_

Family dentist \_\_\_\_\_ Phone # \_\_\_\_\_

\*\*\*\*\*

The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in providing appropriate care. Any changes to this form should be given to camp health personnel upon participant's arrival at camp. Provide complete information so that the camp can be aware of your child's needs.

**LIST ALL ALLERGIES AND DESCRIBE REACTIONS**

**Medications** \_\_\_\_\_

**Foods** \_\_\_\_\_

**Other (insect stings, environmental, etc)** \_\_\_\_\_

**LIST ALL MEDICATIONS TO BE GIVEN AT CAMP: (OVER THE COUNTER AS WELL AS VITAMINS OR SUPPLEMENTS)\*\* BY LAW, NO PRESCRIPTION MEDICATIONS WILL BE GIVEN UNLESS IN THE ORIGINAL LABELED BOTTLE WITH THE CAMPER'S NAME, PRESCRIBER'S NAME, NAME OF MEDICATION, DOSAGE AND INSTRUCTIONS FOR ADMINISTRATION. NO PROFESSIONAL SAMPLES WITHOUT PRESCRIBER LABEL.**

\_\_\_\_\_ **This camper takes no medications.**

\_\_\_\_\_ **This camper takes the following medications on a routine basis.**

**Medicatio** \_\_\_\_\_ **Dosage** \_\_\_\_\_

**Times taken each day** \_\_\_\_\_ **Reason** \_\_\_\_\_

**Medicatio** \_\_\_\_\_ **Dosage** \_\_\_\_\_

**Times taken each day** \_\_\_\_\_ **Reason** \_\_\_\_\_

**Other** \_\_\_\_\_

**Medicatio** \_\_\_\_\_ **Dosage** \_\_\_\_\_

**Times taken each day** \_\_\_\_\_ **Reason** \_\_\_\_\_

**Other** \_\_\_\_\_

**Medicatio** \_\_\_\_\_ **Dosage** \_\_\_\_\_

**Times taken each day** \_\_\_\_\_ **Reason** \_\_\_\_\_

**Other** \_\_\_\_\_

**Past medical history: List hospitalizations, serious or chronic conditions and any injuries that required medical intervention in the past 5 years.** \_\_\_\_\_

**EMERGENCY AUTHORIZATION: The health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted. I hereby give permission to the camp to provide routine first aid, administer prescribed medications and seek emergency medical treatment including x-rays or interventions as deemed necessary. I also grant permission to the licensed provider selected by this camp to hospitalize, secure proper treatment, order injections and/or anesthesia and/or surgery as judged appropriate for the situation. I further authorize the release of medical information to any provider, insurance company and medical facility that may need access to complete their care. I have, and do hereby, release The Cathedral Domain, its employees or agents from liability associated with participation in camp activities. I understand that if I do not have medical insurance, I, as the participant/parent/guardian, will be responsible for any and all medical expenses in the event of illness and/or injury. I understand that there are risks involved in participating in a residential camp and its activities. There has been a wellness examination of this camper within the last two years.**

**SIGNATURE OF PARENT/GUARDIAN** \_\_\_\_\_

**PRINTED NAME** \_\_\_\_\_ **DATE** \_\_\_\_\_

Please circle any of the following conditions that apply to the participant:

- |                    |                              |
|--------------------|------------------------------|
| Asthma             | Frequent ear infections      |
| Bed-wetting        | Passed out after exercise    |
| Sleepwalking       | Become dizzy during exercise |
| Any recent injury  | Chest pains                  |
| Seizures           | Heart murmur                 |
| Back problems      | Skin problems                |
| Eating disorder    | High blood pressure          |
| Frequent headaches | Diabetes                     |
| Joint pain         | Surgery of any type          |
| Head injury        | Infectious disease           |
| Hospitalized       |                              |

Please explain any circled answers \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has the participant had mononucleosis in the past year? \_\_\_ Yes \_\_\_ No

If female, has the participant had an abnormal menstrual history? \_\_\_ Yes \_\_\_ No \_\_\_ N/A

Has the participant ever had emotional difficulties where professional help became necessary?  
\_\_\_ Yes \_\_\_ No

Circle the following the participant had?

Measles, Mumps, Chicken Pox, German Measles, Hepatitis A, Hepatitis B, Hepatitis C

Are immunizations up to date? \_\_\_\_\_ If not, explain \_\_\_\_\_

Last tetanus injection \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Last TB skin test \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Result? \_\_\_\_\_

Camper's Name \_\_\_\_\_

I examined this individual on \_\_\_\_\_  
(ACA accreditation requirements specify wellness exams within 24 months of camp attendants)

Height \_\_\_\_\_      Weight \_\_\_\_\_      B/P \_\_\_\_\_

In my opinion, the above applicant \_\_\_\_ (is) \_\_\_\_ (is not) able to participate in an active camp program.

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

**Recommendations and Restrictions at Camp:**  
Treatment to be continued at camp: \_\_\_\_\_  
\_\_\_\_\_

Medications to be administered at camp (name, dosage, frequency) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Any medically prescribed meal plan/dietary restriction: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Known allergies: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Description of any limitation or restriction on camp activities: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Additional information for health care staff at the camp: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SIGNATURE OF LICENSED MEDIAL PERSONNEL**

\_\_\_\_\_  
Printed \_\_\_\_\_ Title \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Date \_\_\_\_\_