

King Pine Ski Camp Immunization and Medical History Form

Participant's Name:

Home Phone:

Address:

City:

ST:

ZIP:

Age:

Date of Birth:

M / F

Email:

IMPORTANT !

Medical Waiver - MUST BE SIGNED BY PARENTS:

In the event of my daughter's/ son's illness or injury. I would expect to be notified, but if I am unavailable I grant permission to adult leaders to authorize immediate medical treatment for my daughter/ son.

Parent's Signature

Date

If you have medical Insurance would you please list the Company and Policy Number.

Ins. Company

Policy No.

Address

Please Note: Skiing and Snowboarding are inherently dangerous activities. Every precaution will be taken, but it is understood that Purity Spring Resort, Inc. cannot be held responsible in case of an accident. Purity Spring Resort, Inc. cannot be held responsible for lost or stolen equipment, it is the child's responsibility to keep track of his or her personal gear.

Immunization Records - A copy of school records is acceptable along with school physical. (Please make sure all questions on form below are answered.)

Required immunization must be determined locally. Please record the date (month and year) of initial immunization and last booster.

| Vaccines | | Year of Initial | |
|---|-------------------------------|-----------------|--------------|
| | | booster | Last Booster |
| DPT | Diphtheria 1: | | |
| | Pertussis (whooping cough) 2: | | |
| OR | Tetanus 3: | | |
| | Tetanus: | | |
| OR | Diphtheria: | | |
| Tetanus: | | | |
| Oral Polio (Sabin) TOPV: | | | |
| Injectable Polio (Salk): | | | |
| Measles (hard measles, red measles, Rubeola): | | | |
| Mumps: | | | |
| Rubella (German Measles, 3-day measles): | | | |
| Other: | | | |
| Tuberculin test given: | | (most recent) | |

Health Examination by Licensed Physician - MUST BE FILLED OUT BY PHYSICIAN FOR YOUTH SKI CAMP SKIERS: The applicant is under the care of a physician for the following condition(s):

Current treatment (include current medications): _____

Explanation of any reported loss of consciousness, convulsion, or concussion: _____

Does the applicant have epilepsy? Yes ____ No ____ Does the applicant have Diabetes? Yes ____ No ____

I have examined the camp applicant within the past two years. Date Examined: ____/____/____

In my opinion this applicants condition does ____/ Does not ____ preclude his/ her participation in an active camp program.

Any Treatment to be continued at camp (specify dosages): _____

Any medically prescribed meal plan or dietary restrictions: _____

Any Allergies (Food, drugs, plants, and insects, etc.): _____

Additional Health Information:

Licensed Physician's Signature: _____ Phone: _____

Address: _____

Date of Form Completion: _____ By: _____

Initial if completed by nurse of physician's assistant