

# SWIM WITH THE STARS CAMP 2007

## Medical Fact Sheet

**\*\*Each camper must have a completed medical fact sheet prior to participation.\*\***

Name of Child: \_\_\_\_\_

Home Address of Child: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

### EMERGENCY INFORMATION

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Health Care Provider (Name): \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Insurance Carrier (Name): \_\_\_\_\_

Policy Number: \_\_\_\_\_ Name of Policyholder: \_\_\_\_\_

### PLEASE COMPLETE THE FOLLOWING QUESTIONS:

**Inhaler:** If your child uses an inhaler, do you give him/her permission to keep the inhaler with him/her at camp

and to use as needed? **YES** \_\_\_\_\_ **NO** \_\_\_\_\_

**EPI-Pen:** Will your child require, if needed, the use of an epi-pen? **YES** \_\_\_\_\_ **NO** \_\_\_\_\_

My child **CAN/CANNOT** (circle one) administer the epi-pen without assistance.

If your child cannot administer the epi-pen, will your child require the assistance of an adult to administer the epi-pen? **YES** \_\_\_\_\_ **NO** \_\_\_\_\_

My child is allergic to: \_\_\_\_\_

Describe the severity of the allergy/reaction: \_\_\_\_\_

Symptoms of such allergic reaction include: \_\_\_\_\_

**Medication:** My child is on the following medications:

Medicine Medical Condition Amount per dose # doses per day

\_\_\_\_\_  
\_\_\_\_\_

Will your child require medication to be administered at camp?

\_\_\_\_\_

If yes, please fill out the AUTHORIZATION TO ADMINISTER MEDICATION TO A CAMPER form.

## **AUTHORIZATION TO ADMINISTER MEDICATION TO A CAMPER**

(To be completed by parent/guardian and countersigned by the Health Care Consultant)

Name of Camper: \_\_\_\_\_ Age: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Food/Drug Allergies: \_\_\_\_\_

Home Telephone: \_\_\_\_\_

Diagnosis (at parent's discretion) \_\_\_\_\_

Business Telephone: \_\_\_\_\_ Emergency

Telephone: \_\_\_\_\_

Name of Licensed Prescriber: \_\_\_\_\_ Business

Telephone: \_\_\_\_\_

Emergency Telephone: \_\_\_\_\_

Name of Medication: \_\_\_\_\_ Dose given at camp: \_\_\_\_\_

Route of Administration: \_\_\_\_\_

Frequency: \_\_\_\_\_ Date Ordered: \_\_\_\_\_ Duration of Order: \_\_\_\_\_

Quantity Received: \_\_\_\_\_

Expiration date of Medication received: \_\_\_\_\_

Special Storage Requirements: \_\_\_\_\_

Specific Directions (e.g., on empty stomach/with water,etc.) \_\_\_\_\_

Specific Precautions: \_\_\_\_\_

Possible side effects/adverse reactions: \_\_\_\_\_

Other medications (at parent's discretion): \_\_\_\_\_

Location where medication administration will occur: \_\_\_\_\_

## Agreement

By reading and signing the following Agreement, I/we (hereafter referred to as "I") confirm my understanding of my child's participation in the 2006 Swim with the Stars Camp.

- My child is physically able to participate in the Swim with the Stars Camp and has no medical condition which could affect his/her participation.
- I will be fully responsible for all medical expenses incurred by my child while attending the Swim with the Stars Camp.
- I grant the Swim with the Stars Camp the right to take appropriate actions for my child's health and safety and to obtain the necessary medical assistance.
- I understand that, with the exception of an extreme emergency, no operation will be performed without my being contacted and fully informed.
- I grant the Swim with the Stars Camp the right to administer medications, which I provide, as indicated above.
- I agree to indemnify, defend, and hold harmless Swim with the Stars, Octagon, Inc. its affiliates, subsidiaries, related entities, its parent company and all of its officers, directors, representatives, volunteers, agents, and employees and the athletes participating in the Swim with the Stars Camp from and against any claims, causes of action, damages, judgments, liabilities, fees (including attorney's fees), costs, and expenses in connection the administration of the medication to my child.
- I have read and freely sign this agreement which shall take effect as a sealed instrument.
- I verify that the information on this Health Fact Sheet is accurate.

Parent/Guardian Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_