



Health Information and Permission Form

1069 FFA Circle Road, North Myrtle Beach SC 29582

Organization or Chapter Name: _____

Camper's Last Name First Name Middle Initial

Grade Completed (as of June) Birth Date Gender

Street Address

City State Zip Code

Home Phone # Cell/Work Phone #

Parent/Guardian Full Name Spouse's Name

Person Authorized to Pick-Up Camper Relation to Camper

MEDICAL HISTORY (Please mark all of the following that apply to this camper)

- Contacts/Glasses
- Hard of Hearing/Deaf
- Recent Head, Back, or Neck injury
- Seizure Disorder
- Asthma
- Existing Heart Conditions
- Diabetes
- Skin Conditions
- Joint Problems (recent or chronic)
- Previous Hospitalizations or Surgeries
- Chronic or Recurring Illness (not previously listed)
- Emotional, Social, Learning, or other Mental Health Concerns (ADHD, Anxiety, Depression...)
- Activity Restrictions
- Other Concerns not previously listed If 'Yes' to any of the above, please explain:

Any medications to be administered at camp? Name of medication, times and dosage required:

*Make sure All medications are in original packaging or prescription bottles.

Check All that Apply to Participant:

- Allergies (non life-threatening environmental, medication, food)
- Severe or life-threatening FOOD allergies*
- Other Severe or life-threatening allergies Please list the allergen and describe the allergic reaction, and please provide explanation of child's dietary restrictions.

Please provide any additional information that we should know about the participant:

EMERGENCY CONTACTS (provide 2 emergency contacts)

Name / Relation / Cell Phone / Other Phone

Name / Relation / Cell Phone / Other Phone

Name of Insurance Provider _____

Claims Phone # _____

Policy Holder _____ Policy Holder's DOB _____

Policy # _____ Group # _____

INSURANCE COVERAGE INFORMATION: All campers attending the SC FFA Leadership Center Overnight Camps are covered under the camp's insurance program while attending camp activities for any injuries directly related to activities. A copy of the coverage policy can be made available upon request.

*The most recent copy of the participant's physical will also be accepted in lieu of an examination.
Health Care Recommendations by Licensed Physician, Physician's Assistant, or Registered Nurse

I have examined the above camp applicant. Date Examined: NOT NEEDED

NOT NEEDED NOT NEEDED
Licensed Healthcare Professional's Name (Printed) Licensed Healthcare Professional's Name (Signature)

In my opinion, the above's condition **does** / **does not** preclude his/her participation in an active camp program.
(Please circle one.)

Height Weight Blood Pressure

The applicant is under the care of a physician for the following condition(s):

PHOTO RELEASE STATEMENT: By signing this document, I grant permission to use the photographs taken while attending SC FFA Leadership Center Programs for any legal use. Including but not limited to: publicity, copyright purposes, illustration, advertising, and web content.

MEDICAL RELEASE STATEMENT (please read & sign) This health history is correct and complete as far as I know. I agree that SC FFA Leadership Center, its agents, officers, employees, trustees and volunteers will not be liable for any injury, death, damage and/or loss to myself or my child, and/or anyone claiming on my or my child's behalf, and I further agree to hold harmless, indemnify and defend SC FFA Leadership Center, its officers, staff, agents, employees, trustees and volunteers for and from any and all liability, claims, losses, injuries, expenses, fees and/or damages arising out of any injury, illness or death to myself or my child or property damage during my or my child's attendance at SC FFA Leadership Center. The minor child herein has permission to engage in all camp activities as described on the activities waiver unless otherwise noted on the health information form. While SC FFA Leadership Center has safety protocols in place to manage allergen related issues, I understand that a minor with specific allergies or intolerances has a role and responsibility in the avoidance of the known allergen. I agree to educate my child, who has allergies or intolerances, to ask questions, read labels, or abstain from the substance in question when in doubt. I hereby give permission to the camp to provide basic first aid as authorized by my child's PCP. I give permission to SC FFA Leadership Center to seek emergency medical treatment including ordering x-rays or routine tests. In the event of an emergency, I give permission to the camp to arrange necessary related transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the practitioner selected by the camp to secure and administer treatment, including hospitalization, for my child. I hereby authorize SC FFA Leadership Camp's health officials to share health information and health history with the other staff members on a need to know basis. This includes the camp director, program directors, and counselors that have the minor in their care. The purpose of this disclosure is for the necessary staff to be prepared in advance for any medical emergencies. I agree to the release of any records necessary for insurance purposes. The health information that may be disclosed will be from the Health Information Form, and Immunization Records. This authorization is valid for the year of 2022. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I also understand that this information is released to aid in the treatment and care of my child.

Parent/Guardian Signature _____ Date _____