2012 MICHIGAN YOUTH TROUT CAMP
INSURANCE AND MEDICAL

Last Name ______________________________ First Name _______________________________

Birth Date __________________________ Age________ Gender _____ Male _____ Female

Parent or Guardian's Name ____

Address ____

City ____State ____________ Zip _________

Home Phone (   ) ___________________ Business Phone (   ) _____________________

Parent's Cell Phone (   ) ____________________

If not available in an emergency, notify

____

Home Phone (   ) ___________________Business Phone (   ) _____________________

NO STUDENT WILL BE ACCEPTED AS A PARTICIPANT WITHOUT HEALTH INSURANCE OR OFFICIAL PROOF OF MEDICAID

I understand the Michigan TU Trout Camp has no health or accident insurance on participants.
(You must attach a copy of your health insurance card.)

Name of Insurance Co.:____

Name of Policy ____

Policy or Group Number____

Address ____

City, ____ State______ Zip____________

Phone (   ) _____________________

SPONSORED BY KALAMAZOO VALLEY CHAPTER OF TROUT UNLIMITED

2012 MICHIGAN YOUTH TROUT CAMP
INSURANCE AND MEDICAL

PARENT/PARTICIPANT AGREEMENT:
This health history is correct so far as I know, and the child named above has permission to engage in all prescribed camp activities except as noted, the staff of Michigan TU Trout Camp exercises caution in the conduct of all camp activities; however, they do no assume responsibility for accidents, injury or illnesses suffered by its participants.
I, as a parent or guardian of the child named above, individually and on behalf of the participant, hereby release, discharge and agree to indemnify the Michigan TU Trout Camp, their directors, volunteers, and employees from all liability for damage, injury or illness to the participant or their property relating to or deriving from their stay at the Michigan TU Trout Camp or participation in or travel to or from the Michigan TU Trout Camp activities.
I, as a parent or guardian of the child named above, hereby grant permission for the Michigan TU Trout Camp to use any photographs of the participant taken during the camp sessions in newspapers, magazine, or brochures or other media for promotional purposes.

AUTHORIZATION FOR TREATMENT:
I, as parent or guardian of the child named above, hereby give permission to the medical or dental personnel selected by the camp to order X-rays, routine tests, treatment for the participant and necessary transportation for my child. In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, order injections, anesthesia, or surgery, including hospitalization for the child named above. The completed forms maybe photocopied for trips outside of the camp. I further acknowledge that I will be responsible for payment of all charges related to the medical or dental services provided. I also give permission to the camp nurse to administer over the counter medications and physician ordered medication in cases deemed necessary by the camp medical staff and the Michigan TU Trout Camp Director.

Parent Signature: ____ Date: _______________

2012 MICHIGAN YOUTH TROUT CAMP
INSURANCE AND MEDICAL

PLEASE FILL IN INFORMATION BELOW:

Allergies to Drugs ____

Any other known allergies ____

Recent exposure to contagious disease yes __________ no __________

If yes, name disease and date ____

List serious or chronic illnesses that the child has ever had and operations or serious injuries.

____

Health history — Does your child have any of the following? For all yes answers please mark "x' in the box and explain in the space provided, include your usual method of treatment and have your child bring to the criteria the medication required

___ high blood pressure ___sleepwalking ___frequent sore throats ___seizures

___stomach upsets ___ asthma ___ bronchitis ___fainting spells ___ear problems

___skin rashes/problems ___diabetes ___fainting spells ___athlete's foot

___hayfever/sinus problems ___reactions to insect bites/stings/poisonous plants

___other ____

List medicines taken daily/dosages: ____

Describe any other health conditions requiring treatment or restrictions:

Which of the following has your child had? ___ measles ___chicken pox ___German measles

___Mump ___Hepatitis

IMMUNIZATION RECORD BE COMPLETED BY PARENT OR PHYSICIAN

Please send a copy of the immunization record or complete below; listing the last date vaccine was given.

DTP/DPTA ____________________ Tetanus ____________________

MMR _________________________ Polio_______________________

Hepatitis B_____________________

SPONSORED BY KALAMAZOO VALLEY CHAPTER OF TROUT UNLIMITED