



Name of Camp: _____ Camp Date: _____

NRCP Children's Summer Nature Camps Information Form

Please complete this form and return to NRCP at least one week prior to your youth attending camp.

Participant:

Name: _____ Sex: _____ Grade In Fall: _____

School: _____ Birthdate: _____ Home phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Parent/Guardian:

Name: _____ Email _____

Employer: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Parent/Guardian:

Name: _____ Email _____

Employer: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Billing Address: (If different than above)

Contact Person: _____ Relation to youth: _____

Address: _____ City: _____ State: _____ Zip: _____

Medical Contacts:

Physician Name: _____ Phone: _____

Last Date of Physical: _____ Due Date of Next Physical: _____

Dentist Name: _____ Phone: _____

Emergency Contacts/Pick-Up Authorization: (other than the parents listed above)

(Please list authorized people to pickup your youth, other than parents. Identification by photo ID may be required at any time.)

1.) Name: _____ Relationship to youth: _____

Phone #: _____ Second #: _____ Third #: _____

2.) Name: _____ Relationship to youth: _____

Phone #: _____ Second #: _____ Third #: _____

3.) Name: _____ Relationship to youth: _____

Phone #: _____ Second #: _____ Third #: _____

NRCP Signature Form

Please complete this form and return to the NRCP at least one week prior to your youth attending camp.

Read and Initial all sections

Liability Waiver:

_____ This health history is correct so far as I know and the person herein described has permission to engage in all prescribed activities including field trips and photos for promotional purposes. I agree to follow the rules, guidelines, procedures, and policies described in the Parent Information Packet. The undersigned hereby agree to hold harmless and indemnify NRCP and/or any of its employees and/or volunteers from and against any claims, demands, liability, costs of suit, damages, loss and/or judgments in connection with any use of NRCP properties.

Emergency Authorization:

_____ I hereby give permission to the medical personnel selected by NRCP staff to order x-rays, routine tests and treatment for my youth. In the event that I can not be reached in an emergency, I hereby give permission to transport, hospitalize, secure proper treatment for and to order injection and/or anesthesia and/or surgery for my youth. I accept financial responsibility if such treatment is necessary. I understand that this consent does not waive or diminish my rights.

Photo/Video Waiver:

The Nature and Raptor Center of Pueblo uses photographs or video taken during programs for marketing and public relations purposes. Photos may appear in our quarterly newsletter, the local newspaper, *The Pueblo Chieftain*, on our website, www.natureandraptor.org, or in other publications. We may also send photos or video to companies and individuals who make contributions or donations to NRCP programs for use in their publications. We would like your permission to use any photos or video taken. We will make every attempt to notify you and provide copies of any publication(s) in which your child appears.

Initial one:

____ I, _____ (Signature of parent/guardian), hereby give NRCP and affiliates permission to publish photographs of my child taken during NRCP programs.

____ I do not give NRCP permission to publish photos of my child taken during NRCP programs.

All the above must be initialed by the guardian of the youth listed in order to participate in NRCP Summer Camp Activities.

Insurance Information:

Youth's Legal Name: _____ School: _____

Insurance Company: _____ Policy/Group #: _____

Name of Policy Holder: _____ Relationship to youth: _____

Signature

Date

Parent/Guardian Name Printed

NRCP Health Form

Please complete this form and return to NRCP at least one week prior to your youth attending camp.

Health History

Youth's Name: _____ School: _____

(Please check if your child has any of the following or has had, and please give approximate dates.)

_____ Frequent Ear Infections	_____ Heart Defect/Disease
_____ Convulsions/Seizures	_____ Diabetes
_____ Bleeding/Clotting Disorders	_____ High Blood Pressure
_____ Mononucleosis	_____ Epilepsy
_____ Chicken Pox	_____ Measles
_____ German Measles	_____ Mumps
_____ Frequent Headaches	_____ Infectious Disease
_____ Chest Pains	_____ Dizziness from exercise

Allergies

_____ Hay Fever _____ Insect Stings _____ Penicillin _____ Asthma _____

Foods (please List) _____

In case of illness or injury, please mark which over-the-counter medications NRCP may give your child:

OK to give	Medication*
	Tylenol
	Ibuprofen
	Pepto-Bismol
	Benadryl

Immunizations

Copies of immunization forms from health care providers or state or local government are acceptable; please attach to this form. Copy of immunization records attached to form? YES ☐ NO ☐

Date of last Tetanus _____

NRCP Physician's Form

Please complete this form and return to NRCP at least one week prior to your youth attending camp.

NOTE: Prescription medication must be brought to the NRCP Youth Program in its original pharmacy container appropriately labeled by the pharmacy along with this medication permission.

Physician's Examination

Youth's Name: _____ School: _____

I have examined the above individual and will verify the following:

Date of Examination: _____ BP: _____ Weight: _____ Height: _____

In my opinion, the above applicant _____ is _____ is not able to participate in an active youth development program.

The applicant is undergoing care of a physician for the following conditions: _____

Current Treatment at the time of this report includes: _____

Contact with tuberculosis: _____ Date of Tuberculin Test: _____ Result: _____

If Chest X-rayed: _____ Date X-rayed: _____ Result: _____

Any medical-prescribed dietary restrictions: _____

Additional information for health care staff: _____

Medication Permission

Medication: _____ Dosage: _____ Route: _____

Purpose of Medication: _____

Warning signs that may indicate an onset illness: _____

Possible side effects: _____

Anticipated Number of days it needs to be given at the NRCP Program: _____

Parent/Guardian & Physician

I hereby give permission for the above individual to take the above prescription or over-the-counter medication at the NRCP Program facility as ordered. I understand that it is my responsibility to furnish medication.

Parent Name (Printed)

Parent (Signature)

Date: _____

Licensed Medical Professional Name (Printed)

Title

Phone

Licensed Medical Professional (Signature)

Date: _____