UNIVERSITY OF NORTH CAROLINA WILMINGTON

# PARTICIPANT INFORMATION AND MEDICAL RELEASE LONG FORM

Program registering for ________________________________ Date ____________________________

Name of Participant/Camper ____________________________________________________________

Male Female Date of Birth ________/______/______

Parent/Guardian Name *(if applicable)* ____________________________________________________

Home Address ______________________________________________________________________

City ______________________________________ State ________ Zip ________________

Day Phone (___)____________ Cell Phone (____)_______________ Evening Phone (___)_____________

Parent/Guardian Email *(print clearly)* ____________________________________________________

**Alternate Emergency Contacts:**

Primary Contact ____________________________________ Day Phone (____)_________________

Relationship __________________________________ Cell Phone (____)_________________

Secondary Contact __________________________________ Day Phone (____)_________________

Relationship __________________________________ Cell Phone (____)_________________

**If the student must leave the program** for any reason and you cannot be reached, there must be another adult available who will take responsibility for removing the student from the campus.

**Name(s) of adult(s)** ***other than parent/guardian*** **authorized to act on your behalf in this situation**:

Name _____________________________________________ Day Phone (____)__________________

Cell Phone (____)__________________

Name _____________________________________________ Day Phone (____)__________________

Cell Phone (____)__________________

**Physician or clinic you usually consult for medical care**:

Name ______________________________________________ Phone (____)______________________

**Medical Information:** Date of last tetanus immunization _____/______/______

Allergies _____________________________________________________________________________

______________________________________________________________________________________

Drug Sensitivities _____________________________________________________________________

Current medical/psychological/behavioral problems being treated _____________________________

______________________________________________________________________________________

Current restrictions/recommendations due to medical condition(s) ________________________________________

______________________________________________________________________________

Current medications, reason for taking ________________________________________________

______________________________________________________________________________

What accommodations should be made to insure proper administration and storing of the medication? __________

______________________________________________________________________________

Past medical/psychological problems staff should be aware of _____________________________________

______________________________________________________________________________

Is an identification band or card carried to alert others to the allergy(ies), medical conditions or medication use?

Yes No

Please note that if your child refuses to take their prescribed medicine as directed, they may be sent home.

If your child is dealing with any type of learning disability or on a behavioral management plan that you think we should be aware of, please consider sharing this information with us so their camp experience will be successful.

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

**The Program's activities may inhibit or prevent participation**. If any of these conditions pertain to you, you may VOLUNTARILY indicate by circling the information below. *(Information will be shared ONLY with pertinent Program staff or medical professionals).*

| | | |
|---|---|---|
| 1. Motion sickness | 12. Diabetes | 23. Hay fever |
| 2. Hospitalized | 13. Tuberculosis | 24. Asthma |
| 3. Serious Injury | 14. Bronchitis | 25. Trouble equalizing pressure in sinuses/ears |
| 4. Back problems | 15. Claustrophobia | 26. Frequent colds or sore throat |
| 5. Physical handicap | 16. High blood pressure | 27. Severe or frequent headache |
| 6. Regular medication | 17. Respiratory problems | 28. Ear or hearing problems |
| 7.Allergies, including drugs | 18. Persistent cough | 29. Alcohol or drug problems |
| 8. Dizziness or fainting | 19. Pregnant | 30. Mental or emotional problems |
| 9. Epilepsy | 20. Chest pains | 31.Current communicable disease |
| 10. Heart trouble | 21. Contact lenses | 32. Rejected from an activity for medical reasons |
| 11. Sinus trouble | 22. Dental plates | 33. Any medical problem not listed |

Knowing these health risks, is your child capable of participating in this activity? Please answer if you will/she/he may participate. Yes No

If yes, print or type remarks: ______________________________________________________

______________________________________________________________________________

______________________________________________________________________________

I agree to notify the camp director by the registration deadline of any change that may occur in his/her physical or mental health prior to arrival at the Program or in the course of his/her attendance there.

**Swimming Level** *(check one)* Unable to Swim Weak Average Strong

**Do you have health insurance?** Yes No
*(At the sole discretion of the Program, proof of insurance may be required before participation.)*

Insurance Company's Name ______________________________________________

Medical/Hospitalization Insurance Policy # ___________________________________

Phone Number of Office Holding Policy (______)_______________________________

- **I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.**
- **I AUTHORIZE THE ABOVE LISTED ADULT(S) TO TAKE CHARGE OF THE STUDENT IF HE OR SHE MUST LEAVE THE PROGRAM AND I CANNOT BE REACHED.**

______________________________________________________________________________

CAMPER/STUDENT'S SIGNATURE DATE

______________________________________________________________________________

CUSTODIAL PARENT'S OR GUARDIAN'S SIGNATURE *(Signature of one parent binds both parents)* DATE

____________________________________ ____________________________________

PRINTED NAME OF PARENT PRINTED NAME OF CHILD

____________________________________

Name of camp your child is attending