



## CAMP NEW HAPPENINGS NORTHERN INDIANA

Sponsored By  
The Episcopal Diocese of Northern Indiana

### Medical Information and Medical Release Form

#### Participant Information

Name \_\_\_\_\_  
Gender (M/F) \_\_\_\_\_ Age \_\_\_\_\_  
Address \_\_\_\_\_  
City/State/Zip \_\_\_\_\_  
Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_  
Birth date \_\_\_\_\_  
Insurance Co. \_\_\_\_\_  
Insured's Name \_\_\_\_\_  
Policy or ID # \_\_\_\_\_  
Group Name or # \_\_\_\_\_

#### Must be completed by family physician

1. Is she/he allergic to any medication: Yes/No; Physical Restrictions: Yes/No; Diet Restrictions Yes/No; If yes, please specify  
\_\_\_\_\_  
\_\_\_\_\_
2. List any medications to be brought to camp along with dose and instructions for use. (Note: All medications must be in the original containers. We cannot accept medications not in original containers under any circumstances.)  
\_\_\_\_\_  
\_\_\_\_\_
3. List any serious illness, surgery, or hospitalization within the past six months.  
\_\_\_\_\_  
\_\_\_\_\_
4. Has she/he seen a doctor within the last three months (Yes/No) If yes, please explain.  
\_\_\_\_\_  
\_\_\_\_\_
5. Is she/he current with immunizations? If yes, please list immunizations or attach immunization record.  
\_\_\_\_\_  
\_\_\_\_\_
6. Please provide the date of the last tetanus shot? \_\_\_\_\_

Physician's Name \_\_\_\_\_  
Address \_\_\_\_\_  
Phone \_\_\_\_\_  
Signature and Date \_\_\_\_\_

**In case of emergency contact**

Name \_\_\_\_\_  
Relationship \_\_\_\_\_  
Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_  
Address \_\_\_\_\_

**Medical Release**

**To Whom It May Concern:**

We, the undersigned parent(s) guardian, hereby give permission for my (our) child to attend and participate in the activities sponsored by Camp New Happenings Northern Indiana.

We authorize an adult, in whose care the minor has been entrusted, to consent to any x-ray examination, anesthetic, medical, surgical or dental diagnosis or treatment, and hospital care, to be rendered to the minor under the general or specific supervision and on the advice of any physician or dentist licensed under the provisions of the Medical Practice Act on the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or said hospital.

The undersigned shall be liable and agree(s) to pay all costs and expenses incurred in connection with such medical and dental services rendered to the aforementioned child pursuant to this authorization.

The undersigned shall not take civil action or legal action against the adult(s) in charge, Camp New Happenings Northern Indiana, The Diocese of Northern Indiana, The Episcopal Church or Camp Alexander Mack for the normal care of the minor in their charge.

Parent/Guardian \_\_\_\_\_  
Signature \_\_\_\_\_ Date \_\_\_\_\_

Return to:  
Camp New Happenings Northern Indiana  
1033 Williams  
Gary, IN 46404  
Telephone: (219) 614-8370