



CAMP/ACTIVITY MEDICAL RELEASE FORM

(to be completed by a parent or guardian)

Name of Student Last: _____ First: _____

Address: _____

City: _____ State: _____ ZIP: _____

Date of Birth: _____ School: _____ Grade: _____

Home Phone Number(s) Father: _____ Mother: _____

Work Phone Number(s) Father: _____ Mother: _____

Cellular Phone(s) Father: _____ Mother: _____

Other Contact Number(s) Father: _____ Mother: _____

Secondary Contact Name: _____ Phone: _____

Relationship: _____

Primary Physician Name: _____ Phone: _____

Address: _____

Primary Dentist Name: _____ Phone: _____

Address: _____

Health Insurance Name: _____ Policy #: _____

Phone: _____

Does your child have any current medical conditions or allergies? _____

Is your child on any regular medications? _____

Other important information: _____

All Wasatch County School District Summer Camp/Activity participants should have current/health/accident insurance. In the event of an injury, if I do not have current health/accident insurance, I hereby authorize the Camp/Activity administration to act for me according to their best judgment in any emergency requiring medical attention. I relieve Wasatch County School District of any responsibility should an accident occur.

Signature of Parent/Guardian _____ Date _____

In case of an emergency or accident, I give the Physician(s) on duty at the hospital, chosen at the discretion of the Camp/Activity staff or counselors, permission to administer emergency medical care and/or treatment to my son/daughter name above. I relieve Wasatch County School District of any responsibility in making these decisions.

Signature of Parent/Guardian _____ Date _____