

**YMCA Camp Jewell Outdoor Center  
Health Information and Emergency Permission**

*This form is required on site for every person under 18 yrs. of age, not accompanied by a parent or guardian. It must be presented at the Center office upon check in and retained by the group leaders. Forms may be needed at any time for an emergency. Please Print all information clearly.*

School or Group Name \_\_\_\_\_

Dates at Jewell \_\_\_\_\_

(child's name) \_\_\_\_\_ has my permission to participate in the trip to YMCA Camp Jewell Outdoor Center on the above dates.

Please list, with dates, any major illness or injury this child has had:

within the past month \_\_\_\_\_

within the past year \_\_\_\_\_

Date of Tetanus Shot (should be within ten years) \_\_\_\_\_

List any Allergies (medication, inhalant, or food) \_\_\_\_\_

Can this child take part in strenuous physical activities? \_\_\_\_\_

The following medication will be needed by this child at Camp. (All medication should be given to the group leader before leaving to come to camp. It may not be carried by the child)

Medication	Amount and Time to be given
_____	_____
_____	_____

I hereby give permission to Camp Director, group leader, or their designate to administer the above medication in the absence of a nurse.

Additional information and remarks:

\_\_\_\_\_  
\_\_\_\_\_

I understand that every attempt will be made to contact me in the event of accident or injury, but that it might be impossible in an emergency to contact me quickly enough to authorize proper treatment. Therefore, I authorize the officials of my child's group and the directors of Camp Jewell to seek the proper treatment in the event of any accident or injury. I give my permission for the use of any form of medical treatment necessary; such as, injections, anesthesiology, medicines, drugs, surgery, or other treatment which is deemed necessary by attending nurses and physicians, and also authorize transportation of my child by either private vehicle or ambulance in order to facilitate any necessary treatment.

Date \_\_\_\_\_ Phone # \_\_\_\_\_

Signature of Parent or Guardian (circle one) \_\_\_\_\_

Other emergency phone numbers if parent can not be reached:

Name \_\_\_\_\_ Phone \_\_\_\_\_

Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Family Doctor \_\_\_\_\_ Phone \_\_\_\_\_

Insurance Carrier \_\_\_\_\_ Policy Number \_\_\_\_\_

Child's Last Name

First

Middle Initial