**PGCPS Saturday School Health Form**

This form must be completed and signed by the participant’s legal guardian. The information we ask you to provide is necessary in the event your child needs medical treatment while camp is in session. **This form will be returned to you if it is incomplete**. Please type or print in **black ink.**

**PARTICIPANT INFORMATION**

Participant’s Name

Permanent Address Date of Birth Sex

City/State/Zip Home Phone

**MEDICAL EMERGENCY CONTACT INFORMATION**

Person to contact first: Backup contact (relative or friend):

Name Name

Relation Relation

Daytime Phone Daytime Phone

Evening Phone Evening Phone

**MEDICAL TREATMENT CONSENT**

I, the legal guardian of the above-named student, authorize the Community Youth Advance in partnership with PGCPS Saturday School Program staff to seek medical treatment for the student as they see necessary at the nearest medical facility. I consent to any x-ray, anesthetic, medical or surgical diagnosis or treatment and hospital care subsequently deemed necessary by a licensed health care provider during the participant’s session. I understand that this authorization is given in advance of any specific diagnosis, treatment or hospital care, and that it is given to provide the program staff authority to seek medical treatment, and to provide a licensed health care provider the authority to administer this treatment as s/he judges necessary to the above-named child. I accept responsibility for payment of all services rendered; I authorize any medical facility which renders services to release medical information necessary for the processing of insurance claims; and I authorize the payment of insurance claims directly to the medical facility. I understand that whenever possible, the Program staff will make a good faith effort to contact me or the above-named person(s) before seeking treatment. If this is not possible, I understand that the Program staff will notify me or my designee as soon a possible of any and all diagnoses and treatments.



Legal Guardian’s Signature Print Name Date

**Directions**: Completion of this form by a parent or guardian is required before a student can participate. Please answer all questions. **Incomplete forms will be returned to you for the missing information**. Please type or print in black ink. Attach any specific recommendations from your physician to this form.



**DOES THE PARTICIPANT CURRENTLY HAVE ANY OF THE FOLLOWING?** (if yes, please describe)

Drug allergies:

Food allergies:

Allergies to insect bites:

Special dietary needs:

Asthma:

Frequent headaches:

Dizziness or seizures:

**LIST:** Other health problems:

Limitations of Activities:

Medications the camper is currently taking:

(**Please note:** Our staff cannot administer any medications, prescription or non-prescription to campers. This includes over-the-counter medicines like Advil or Tylenol for minor headaches or pains. If the camper will need to take medications while attending our program, s/he must bring the medication to camp and assume responsibility for taking it as needed or indicated.)

Will your son/daughter require any specific treatment for a medical/emotional condition while participating in our program? If yes, please explain. yes no

**PHYSICIAN’S INFORMATION** *(to be completed by physician)*Please **PRINT** the following information:

Physician’s Name:

Address:

City/State/Zip

Telephone

*I have examined the above named participant and found she/he to be able to participate in all activities of the PGCPS Saturday \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ School Program.*



Physician’s Signature Print Name Date