

STEM CAMP USA LLC

Emergency Medical Release 2018

THIS FORM SHOULD BE COMPLETED AND RETURNED TO STEM CAMP USA

Participant's Name _____ Birthdate _____

Street Address _____ City _____ State _____ Zip _____

EMERGENCY INFORMATION

Father's Name _____ Home Phone (____) _____ Bus Phone (____) _____

Cell Phone (____) _____

Mother's Name _____ Home Phone (____) _____ Bus Phone (____) _____

Cell Phone (____) _____

In an emergency when parent/guardian cannot be reached, please contact the following:

Name _____ Home Phone (____) _____ Bus Phone (____) _____

Name _____ Home Phone (____) _____ Bus Phone (____) _____

Allergies _____ Last Tetanus _____

**Stem Camp USA cannot be responsible for accommodating any food allergies.*

Other medical conditions _____

Medication being used (include dosage/frequency) _____

Present state of health _____

Family Physician _____ Phone (____) _____

Medical/Hospital Insurance Company _____ Phone (____) _____

Policy Holder's Name _____ Policy Number _____

AUTHORIZATION FOR TREATMENT OF MINOR

I, the undersigned, understand and acknowledge that every effort will be made to contact the parents in case of an emergency, and, if possible, before any medical treatment is administered. In the event of an emergency or if the parents cannot be notified, I hereby give permission to the Program Leader or the Stem Camp USA staff to secure proper treatment for my child, including having access to any and all medical records. If necessary, this includes selection of physicians and medical treatment facility who are then authorized to perform such medical treatments as deemed necessary to protect the health of my child.

Stem Camp USA cannot be responsible for accommodating any food allergies, requirements or restrictions and is not responsible for any problems associated with the same. All issues with regard to food and drink, including allergies, requirements and restrictions are the sole responsibility of the participant.

In the event of any emergencies during the trip, the undersigned hereby grants authority to be exercised at the discretion of the Program Leader or chaperone to dispense over-the-counter medication.

Date

Signature of Parent/Guardian

Please return this form to Stem Camp USA on the 1st day of camp.