RENEE FOOSANER EDUCATION CENTER

MEDICAL INFORMATION AND RELEASE
MINOR OR ADULT PARTICIPANT

Please complete form in blue or black ink.

Camp Participant Name ____

Date of Birth *(month/day/year)* ________________________ Age: _____________________ Camp Week: __________

Health/Accident Insurance Carrier

Policy # ____ Group #__________________________________

Personal Physician _______________________________________Physician's Phone ________________________

PARENT, LEGAL GUARDIAN OR OTHER PERSON WHO HAS LEGAL AUTHORITY TO AUTHORIZE MEDICAL TREATMENT TO PARTICIPANT IN CASE OF EMERGENCY. PLEASE CONTACT:

Name ____

Phone ____ Mobile ____

Please list any chronic or acute medical problems or special needs and explain so we can best accommodate your student's camp experience *(continue on separate sheet if needed)*:

____

____

____

List any allergies to food, pollen or medicine: ____

____

List any medications being taken at present: ____

____

Does your child use an EPI Pen: Yes______ No______

I acknowledge the participant's immunizations are current: Yes______ No______

I or MY CHILD plan to attend FLORIDA INSTITUTE OF TECHNOLOGY CAMP, hereinafter referred to as "CAMP." I fully realize that injury or illness could result from or during MY or MY CHILD's participation in the CAMP. In case of accident or injury, I give my permission to receive medical treatment as deemed appropriate. I will assume responsibility for any medical bills.

Parent/Guardian Signature ____

Date __________________________________