

Camper's Name: _____ **Date of Birth:** _____
Address: _____ **Phone Number:** _____

2022 Form Valid for One Camper Only

This form will go with Emergency Personnel. Please fill out EVERY line!

OVER THE COUNTER MEDICATION PERMISSION AND MEDICAL HISTORY

I hereby give Loveland Sports & Academic Day Camp staff permission, *and also release all liability*, when applying or giving one or more of the following over the counter medications or external preparations, in accordance with the directions for use on the container (please check all that apply):

Band-Aids Sunscreen Insect Repellent Other: (please specify) _____

Special Instructions: _____

Parent/Guardian Signature: _____ **Date:** _____

Current and past medical conditions for camper including all allergies, medications, medical concerns, chronic medical conditions, surgeries, broken bones, etc. (if "none" write NONE):

MEDICAL EMERGENCY TREATMENT CONSENT FORM

I give permission for Loveland Sports & Academic Day Camp to provide ALL necessary emergency medical, dental, or other care, including calling 911, for my camper. This care may be given under whatever conditions are necessary to preserve the life, limb or well-being of my dependent. The provider is required to try to contact me, the other parent or legal guardian at one of the below telephone numbers provided. At no time will the provider attempt to drive the sick or injured child to an emergency medical facility.

Parent/Guardian Signature: _____ **Date:** _____

Parent/Legal Guardian: _____ **Cell:** _____

Home Address: _____

Place of Employment: _____ **Work:** _____

Employment Address: _____

Parent/Legal Guardian: _____ **Cell:** _____

Home Address: _____

Place of Employment: _____ **Work:** _____

Employment Address: _____

Emergency Contact (Friend or relative NOT living in the home):

Name: _____ Relationship: _____

Address: _____ Cell: _____

Place of Employment: _____ Work: _____

Employment Address: _____

Insurance Company: _____ **Policy Number:** _____

Physician: _____ Phone: _____

Address: _____

Hospital of Choice:

____ MCR 2500 Rocky Mountain Ave, Loveland 80538 970-624-2500

____ McKee Medical Center 2000 N Boise, Loveland 80538 970-820-4640

____ **Other:** _____ **Phone:** _____

Address: _____

Dentist: _____ **Phone:** _____

Address: _____