Knights of Heroes Medical Release Form

Full Name:_____

Date of Birth:_____

Age:_____ Gender:_____

Address:_____

City:_____ State:_____ Zip: _____ Telephone: _____

Health Insurance Carrier:_____

In case of emergency, notify the person below:

Name:_____ Relationship: _____

Address (if different then address above): _____

Cell Phone: _____

Health History

Do you currently have or have you ever been treated for any of the following:

Yes	No	Condition	Explanation
		Diabetes	
		High Blood Pressure	
		Significant cardiac history (CHF, COPD, Heart Attack)	
		Family history of heart disease or heart attack before the age of 50	
		Stroke	
		Asthma	
		Lung or respiratory disease	
		Chronic ear, eyes, nose or sinus problems	
		Chronic muscular or skeletal problems	
		Significant head injury or concussions	
		Altitude sickness	
		Psychiatric or psychological or emotional difficulties	
		Behavioral or neurological disorders	
		Blood disorders or sickle cell disease	
		Fainting spells or dizziness	
		Kidney disease	
		Seizures	
		Digestive problems	
		Thyroid disease	
		Excessive fatigue	
		Sleep disorder	
		ADD or ADHD	
		Special dietary restrictions	
		Any other medical conditions not listed	

Allergies/Medications

Are you allergic to or do you have any adverse reaction to any of the following:

Yes	No	Allergies or Reactions	Explanation
		Medication	
		Food	
		Plants	
		Insects	

List all medications currently prescribed:

Medication	Dose	Frequency	Reason

Do you authorize camp staff to administer non-prescription medications to your camper (Tylenol, Motrin, Cold Medicine, etc.)

☐ Yes ☐ No

List any exceptions:_____

Administration of above medications is approved for camper by:

_____

Parent/guardian signature

Immunizations

The following immunizations are recommended. Tetanus immunization is required and must have been received within the last 10 years. If you had the disease, check the disease column and list the date. If immunized, check yes and provide the year received. A copy of the shot records can be substituted for this section.

Yes	No	Had Disease	Immunization	Date(s)
			Tetanus	
			Pertussis	
			Diphtheria	
			Measles/mumps/rubella	
			Polio	
			Chicken Pox	
			Hepatitis A	
			Hepatitis B	
			Meningitis	
			Influenza	

Physical Exam

You are being asked to certify that this individual has no contraindications for participation in an outdoor adventure program. This program includes but is not limited to rock climbing, mountain biking, shooting sports, hiking, white water rafting, and other physically demanding activities.

Examiner: Please fill out the following information:

Height (inches): _____ Weight (lbs):_____Blood Pressure: _____/_____ Pulse: _____

	Normal	Abnormal	Explain Abnormalities
Eyes			
Ears/nose/throat			
Lungs			
Heart			
Abdomen			
Genitalia/hernia			
Musculoskeletal			
Neurological			
Other			

Examiner's Certification

I certify that I have reviewed the health history and examined this person and find no contraindications for participation in the Knights of Heroes Summer Camp. This participant does not have uncontrolled asthma, heart disease, diabetes, siezures or hypertension.

Examiner's Signature:_____ Date: _____
(Licensed physician or nurse practitioner)

Provider's printed name: _____

Address: _____

City: _____ State: _____ Zip code:_____

Office phone: _____

***This medical examination is valid for 24 months from the date signed**