Kokushikai Judo Camp Medical Release & Authorization Form 2012

This form must completed with a physician's signature and returned in the envelope provided before the camp session begins in order for the camper to be permitted to participate in any camp activities.
Mail completed form by August 5, 2012 to: Kokushikai Judo Camp, P.O. Box 802, New York, NY 10024

Full Name of Camper, Volunteer or Staff Member: _____

General Information (Verify that this information is correct)

D.O.B: _____/_____/_____ Age:_____ ☐ Female ☐ Male

Emergency Contact #1: _____Relationship to Camper:_____

Daytime Phone _____Cell Phone:_____

Emergency Contact #2:_____ Relationship to Camper:_____

Daytime Phone:_____ Cell Phone:_____

Medical Practitioner Information

Name of Physician/ Clinic:_____

Address:_____

City/State/Zip:_____ Phone Number:_____

Name of Insurance Co.:_____

Address:_____

Insurance Co. Phone Number:_____

Policy Number:_____ Name of Policy Holder:_____

Physician Examination (Physician is required to fill out the information below)

Height:_____ Weight: _____ Heart: _____ Blood Pressure: _____

Please specify any medical problems, any chronic or recurring illness, or special concerns (physical, mental, emotional), which would affect this individual's participation in camp activities:_____

_____

Please list any past illnesses (contagious or non-contagious), operations, or serious injuries (include dates):

_____

_____

Does the individual wear any medical appliances (glasses, contact lenses, orthodonture, etc.)? ☐ Yes ☐ No If yes, please list:

_____

_____

Recommendations and Restrictions While at Camp:

Please list all allergies (including food, medication, and environmental) or any dietary restrictions

_____

_____

Check the activities that this individual is approved to participate in at camp: ☐ judo/jiujitsu ☐ swimming ☐ walking/jogging ☐ strenuous activity

Other Comments: _____

Will any Medications/Food Supplements/ Etc. be taken by this individual during camp? ☐ Yes ☐ No
(Please use a separate piece of paper to list additional medications if necessary) If yes, please fill out the chart below.

Drug Name	Route	Dosage	Schedule & Indications	Comments

Standard Over the Counter Medications- The following medications are available in the Health Center and will be administered at the discretion of the Camp Physician, with parent/guardian and physican approval. Please select the approved medications below for this camper:

Drug Name	Route	Dosage	Schedule and Indications	Camper Health Care Provider Order	Comments
Ibuprofen (e.g. Advil, Motrin)	PO (Chewable tabs, pills or liquid)	Per label instruction by age/weight	Q 4-6 hrs PRN- Pain, fever, cold symptoms, toothache, muscle aches	YES NO	
Acetaminophen (e.g. Tylenol)	PO (Chewable tabs, pills or liquid)	Per label instruction by age/weight	Q 4-6 hrs PRN- Pain, fever, cold symptoms, toothache, muscle aches	YES NO	
Antacid (Mylanta or Tums)	PO (pills or liquid)	Per label instruction by age/weight	Q 2-4 hrs PRN- Gas, heartburn, indigestion, stomach upset	YES NO	
Robitussin	PO (liquid)	Per label instruction by age/weight	Q 4-6 hrs PRN- Coughs	YES NO	
Cough drops and Lozenges	PO (lozenges)	Per label instruction by age/weight	PRN- Coughs, sore throats	YES NO	
Diphenhydramine (e.g. Benadryl)	PO / Topical (pills, liquid or spray)	Per label instruction by age/weight	PRN- Insect bites, allergies, respiratory allergies	YES NO	
Pseudoephedrine (e.g. Sudafed)	PO (Chewable tabs, pills or liquid)	Per label instruction by age/weight	Q 4-6 hrs PRN- Nasal/sinus congestion, hay fever, allergies	YES NO	
Ivy Block and Tecnu	Topical (cream)	Per label instruction	Q 4 hrs PRN- Contact with poison ivy	YES NO	
Calagel, Calamine and Hydrocortisone	Topical (cream or gel)	Per label instruction	Q 6-8 hrs PRN- Insect Bites, rash, skin irritation	YES NO	
Antiseptics (Alcohol, Peroxide, Bacitracin)	Topical (cream or liquid)	Per label instruction	PRN- Stings/bites, cuts, scrapes, splinters, blisters	YES NO	
Medicaine	Topical (liquid)	Per label instruction	PRN- Insect stings	YES NO	
Milk of Magnesia	PO (liquid)	Per label instruction	PRN bedtime- constipation	YES NO	
Betadine (**contains Iodine**)	Topical (liquid)	Per label instruction	PRN- Cuts, scrapes, splinters, blisters	YES NO	
Antifungal Cream/Spray	Topical (cream or spray)	Per label instruction	PRN- Athletes foot, jock itch	YES NO	
Cooling Gel and Aloe	Topical (cream or gel)	Per label instruction	PRN- Burns, sunburn, wind burn	YES NO	
Muscle Rub	Topical (cream)	Per label instruction	PRN- Minor muscle strains or pains	YES NO	
Orasol, Ambesol and Abreva	Topical (liquid or cream)	Per label instruction	Q 6 hrs PRN- Oral herpes, cold sores, toothache	YES NO	
Antihistamine Eye Drops	Optical (liquid)	Per label instruction	PRN- Eye strain, eye irritation	YES NO	
Nix	Topical (liquid)	Per label instruction	Q 10 days PRN- Head lice	YES NO	

Key: **PRN** (if needed) **PO** (taken by mouth) **Topical** (applied to skin) **Q** (every)

Physician Signature (Required)

I have examined the person herein described and have reviewed the health history. It is my opinion that this person is physically able to engage in camp activities, except as noted above.

_____ _____ _____

Examining Physician Name (Please Print) Examining Physician Signature Date

Authorization for Medical Treatment

I certify that the information above is correct and complete as far as I know. The person herein named has permission to engage in all camp activities except as noted. I hereby give permission to the camp to provide, seek, and consent to routine health care, administration of prescribed medications, and emergency treatment for me/my child, as may be necessary, including , but not limited to x-rays, routine tests and treatment, and/or hospitalization. I also give permission for the camp to arrange related transportation. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I agree to notify Kokushikai Judo Camp of any changes in this individual's physical or mental health between the dates of enrollment and the start of camp. I hereby give consent to the administration of all medical treatments necessary under the judgment of the accredited camp medical personnel, emergency room physicians or any other clinical physicians with the understanding that I (or my emergency contact) will be notified as soon as possible. I agree to assume financial responsibility for medical and hospital expenses. I understand that part of the camp experience involves activities and group living arrangements and interactions that may be new to my child, and that they come with certain risks and uncertainties beyond what I/my child may be used to dealing with at home. I am aware of these risks and I am assuming them on behalf of myself or my child. If I or my child become contagious or very ill I am aware that I or my child may be asked to leave camp for mine or my child's well-being and/or the well-being of others at the discretion of the camp nurse. I realize that no environment is risk-free, and so I have instructed my child on the importance of abiding by the camp's rules. My child and I both agree that he or she is familiar with these rules and will obey them.

_____ _____ _____

Kokushikai Judo Camp Participant (Please Print) Participant Signature Date

_____ _____ _____

Parent/Guardian Name (Please Print) Parent/ Guardian Signature Date

(Parent/Guardian must sign for campers under the age of 18yrs of age.)