LAUNCH Academy | Summer Nutritional Academic Camp (SNAC)

CONFIDENTIAL MEDICAL INFORMATION

Student Name: _____

Dates: June 26, 2023– August 4 , 2023 Time: 8:00am – 4:00pm

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY.

AS A STUDENT, PARENT OR GUARDIAN I UNDERSTAND THAT: The information requested on this form is intended to help inform staff of any pre-existing medical conditions. If your child has a pre-existing medical condition, participation in any strenuous activities or recreational time may not be recommended. ***This information will be kept in strict confidence and will only be shared with your permission.*** The LAUNCH Academy SNAC Program office also requests the information below so that, in case of emergency, we will have accurate information so that we can provide and/or seek appropriate treatment. You are accountable for providing an accurate medical history. ***Final determination about whether to participate is the responsibility of you and your physician***. If you have any medical issue that is not requested below, but which you think is important, please include that information.

PART 1. GENERAL INFORMATION (Print)

Students Name _____

Students Date of Birth _____/_____/_____ Gender: M ___ F ___

Parent/Guardian 1

Parent/Legal Guardian Name _____

Street Address _____

City _____ State_____ Zip code _____

Home Phone _____ Work Phone _____

Cell Phone _____

Email _____

Parent/Guardian 2 (Print)

Parent/Legal Guardian Name _____

Street Address _____

City _____ State_____ Zip code _____

Home Phone _____ Work Phone _____

Cell Phone _____

Email _____

Please list two emergency contacts: (Print)

_____	_____	_____
Emergency Contact #1 Name	Daytime Phone #	Relation
_____	_____	_____
Emergency Contact #2 Name	Daytime Phone #	Relation

PART 2. MEDICAL INFORMATION

It is recommended that you consult with a physician prior to participating in this LAUNCH Academy SNAC Program. If you are uncertain about any preexisting medical conditions, it is your responsibility to consult with your own physician prior to participating in this Summer Program. Please answer all of the questions. If you answer yes to any of the following questions, please explain as indicated. Use back and/or additional paper if needed.

Physicians Name _____ Phone Number: (___) _____-_____

Most recent tetanus toxoid immunization_____

Do you have health/accident insurance? (circle one) Yes No If yes, please indicate policy number, name and address of company. Please also include a copy of the front and back of your insurance card:

Insurance Name _____ Policy # _____

Insurance Address_____

For the following, circle appropriate response and explain as appropriate:

Does the student have any limiting medical conditions that you or your doctor feel would limit their participation? (Circle One) Yes No

If yes, identify and explain: _____

_____

Is student currently taking medication that may interfere with his/her ability to safely participate in the summer program? (Circle One) Yes No

If yes, please indicate the medication and the condition being treated: _____

_____

Does the student have a history of allergies or reactions to medications, insect stings, or plants? (Circle One) Yes No

If yes, identify and explain: _____

_____

Does student have a history of, or currently suffer from, medical condition(s) with which we need to be aware? (Circle One) Yes No

If yes, identify and explain: _____

_____

PART 3: AUTHORIZATION FOR MEDICAL CARE

In cases where medical attention is necessary, parents will be contacted for approval when possible. However, before medical treatment can be provided, we are required to have a medical release signed by the parent. The hospital will not perform services unless this form is presented at the time of treatment.

(_____) [Student Name] has my permission to receive medical attention in the event of illness or medical emergency while participating in the LAUNCH Academy SNAC Program.

I will assume the financial responsibility for any cost of health care for my child that may occur during this Camp.

PLEASE READ: As a participant, parent or guardian I understand and acknowledge that my failure to disclose relevant information may result in harm to myself/my child and/or others during this Program. By signing my name I represent and warrant that I have provided all materials and important information to the LAUNCH Academy SNAC Program Office pertaining to my child's medical, mental and physical condition and that it is accurate and complete. I agree to notify the LAUNCH Academy SNAC Program Office of any changes in my mental, physical or medical condition prior to the first day of the program.

SIGNATURE IS REQUIRED:

Students Name _____

Students Signature _____ Date _____

Parent/Legal Guardian's Name _____

Parent/Legal Guardian's Signature _____ Date _____

PARENT/GUARDIAN MUST SIGN THIS FORM FOR MINORS UNDER THE AGE OF 18