

Cowboy's Rest

CHRISTIAN CAMP & RETREAT CENTER

435 Jiggs Hwy. Unit 4 Spring Creek, NV 89815 ♦ (775) 934-9806 ♦ www.cowboysrest.org

2019 Activity Permission & Medical Release Form

Please complete and sign this form. You may mail it to Cowboy's Rest or bring it with you when you drop off your camper. We **must** receive this form in order for your child to participate and remain at Cowboy's Rest.

Camper Agreement *(must be signed by camper)*

I, _____, will obey all directions and rules given by the Cowboy's Rest staff. If I break any rules, I understand that I could be sent home or not allowed to participate in certain activities during the remainder of camp.

Camper Signature

Date

Parent Permission *(must be signed by parent/guardian)*

My son/daughter, _____ has my permission to participate in activities at Cowboy's Rest Christian Camp in Jiggs, Nevada.

Dates Attending (please check one):

June 10-15 (*High School Camp*)

July 22-26 (*Junior High Camp*)

July 8-12 (*Kid's Camp 1*)

June 24-29 (*Youth Camp*)

July 15-19 (*Kids' Camp 2*)

In the event of a medical emergency, I hereby give permission to the physician selected by the Camp Director to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery for the registered camper named on this form. I also agree to pay for any fees incurred, and I understand that Cowboy's Rest and its staff will not be held responsible or liable for any related expenses.

Parent Signature

Date

Emergency Information

Camper's Name: _____ Gender: _____ Age: _____ Birth date: ____/____/____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Parent/Guardian Names: _____

In case of emergency, please first attempt to contact:

Name: _____ Phone: (____) _____ relation to camper: _____

Other emergency contacts:

Name: _____ Phone: (____) _____ relation to camper: _____

Name: _____ Phone: (____) _____ relation to camper: _____

Name: _____ Phone: (____) _____ relation to camper: _____

Insurance Information

The camper's family insurance plan is the primary source of coverage for accidents.

Insurance Carrier: _____ Phone: _____

Holder's Name: _____ Policy Number: _____

please see reverse

Medical Information

Family Physician: _____ Phone: _____

Date of last Tetanus shot: _____ Activity restrictions? _____

Allergies: _____

Food Allergies: _____

Medications:

Current Medications: _____

I give permission to the camp nurse to administer to my child any of the medications listed below, unless I specify otherwise. (Please initial each medication to indicate permission. Write in any allergies or preferences next to the category.)

Pain Relievers/Fever Reducers: _____

_____ acetaminophen (Tylenol) _____ ibuprofen (Advil) _____ sodium naproxen (Aleve)

Upper Respiratory/Allergy: _____

_____ phenylephrine (Sudafed) _____ diphenhydramine (Benadryl) _____ guaifenesin (expectorant) _____ loratadine (Claritin)

Digestive: _____

_____ simethicone (Gas-X) _____ bismuth subsalicylate (Pepto Bismol) _____ calcium carbonate (Tums)

Topical: _____

_____ Benadryl cream _____ Neosporin _____ lubricating eyedrops

Emergency (parent will be notified): _____

_____ oxygen _____ epinephrine pen

Additional Information for Camp Nurse:

Additional Information for Counselor: *(Is there anything you feel would be beneficial for your child's counselor to know? examples: family, emotional, behavioral, social, or sleep concerns; strengths or weaknesses; likes or dislikes. This information will only be seen by medical staff and the child's counselor.)*