



## VOLUNTEER MEDICAL RELEASE/AGREEMENT FORM

Please fill out the following information and **bring this form with you to Camp**. You will turn in this form and all medications/vitamins to the Nurses.

If you are under 18 years old, it is very important to have a Parent/Legal Guardian Signature below to medically treat a minor.

- All medications (including Birth Control) and vitamins must be in their original containers.
- If you use an inhaler and need to carry it with you please inform our nurse.
- Please do not bring over-the-counter meds. We provide all over-the-counter meds at camp. (*Example; aspirin, Motrin IB, meds for upset stomach, etc...*)

PERSONAL INFORMATION			
Last, First Name (Print)			Camp Position (Print)
Age	Height	Weight	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female

IMMUNIZATION WAIVER
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**\*Only need a parent/guardian signature if you (a minor) have not been immunized.**

We, the parents/guardians of \_\_\_\_\_, take full responsibility for the welfare of our child's health as we have decided not to have him or her immunized. Therefore, we will not hold Resurrection Life Church or Kids Camp responsible in this regard.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

CONSENT OF RELEASE/MEDICAL TREATMENT
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I (volunteer name): \_\_\_\_\_ have read the Kids Camp Policies/Procedures & Job Descriptions.

I understand my role/job description as a volunteer and agree to follow the policies/procedures of Kids Camp. I will not hold Resurrection Life Church, their staff of volunteers responsible in case of injury or illness. I give permission for trained medical personnel to provide routine medical care and/or emergency treatment to the named above and I authorize an adult camp staff personnel to transport me if needed to a medical facility and to sign consent forms for such treatment in the event of illness or injury. I also give ResLife permission to use pictures and images generated at Kids Camp for promotional publication.

**\*\*Camp Ao-Wa-Kiya's insurance is primary insurance\*\***

I hereby give permission to "Camp AO-WA-KIYA", which is licensed by the Department of Consumer and Industry Services, to secure emergency/non-emergency medical and/or surgical treatment for the minor child named above. I further release Camp Ao-Wa-Kiya from all liability beyond the limits of their insurance coverage.

Print First & Last Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Volunteer UNDER 18 years old**

I (parent/legal guardian) the responsible person of this minor/camper/staff, give permission for the name above to participate as a Kids Camp volunteer and agree with all the information provided by Kids Camp and certify that the information provided on this document is correct to the best of my knowledge.

Print First/Last Name (Parent/Legal Guardian): \_\_\_\_\_

Relationship to camper: \_\_\_\_\_

Parent/Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**(UNDER 18) VOLUNTEER MEDICATION FORM**

**ALLERGIES & NOTES**

For Office Use Only!

Print Last Name

Print First Name

<b>LIST ALL MEDICATIONS (USE ANOTHER FORM IF NEEDED)</b>		<b>Office use only</b>			
Medication (Actual name on bottle): _____		B	L	D	B
Strength per unit & form on medication: _____	<b>M</b>				
Units per dose/time of dose: (Put the amount of medication by the time of day)	<b>T</b>				
_____/Breakfast ____/Lunch ____/Dinner ____/Bedtime ____/As Needed	<b>W</b>				
Special Instructions:	<b>T</b>				
	<b>F</b>				

Medication (Actual name on bottle): _____		B	L	D	B
Strength per unit & form on medication: _____	<b>M</b>				
Units per dose/time of dose: (Put the amount of medication by the time of day)	<b>T</b>				
_____/Breakfast ____/Lunch ____/Dinner ____/Bedtime ____/As Needed	<b>W</b>				
Special Instructions:	<b>T</b>				
	<b>F</b>				

Medication (Actual name on bottle): _____		B	L	D	B
Strength per unit & form on medication: _____	<b>M</b>				
Units per dose/time of dose: (Put the amount of medication by the time of day)	<b>T</b>				
_____/Breakfast ____/Lunch ____/Dinner ____/Bedtime ____/As Needed	<b>W</b>				
Special Instructions:	<b>T</b>				
	<b>F</b>				

Medication (Actual name on bottle): _____		B	L	D	B
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Units per dose/time of dose: (Put the amount of medication by the time of day)	<b>T</b>				
_____/Breakfast ____/Lunch ____/Dinner ____/Bedtime ____/As Needed	<b>W</b>				
Special Instructions:	<b>T</b>				
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