



**CAMP TRANSPORTATION AND MEDICAL RELEASE WAIVER**

**PRINTED FULL NAME OF CAMPER** \_\_\_\_\_

**TRANSPORTATION WAIVER AND RELEASE:**

In the event that transportation is provided to an activity by Rebounders Gymnastics, Inc., I hereby give permission for my child to travel to and from those activities in the vehicle provided and agree not to hold Rebounders Gymnastics, Inc., its directors, officers, agents or employees liable for any accident or injury suffered or contracted in connection with such travel.

**MEDICAL ATTENTION:**

I hereby give my consent for Rebounders Gymnastics, Inc. to provide, through a medical staff of its choice, customary medical attentions, transportation, and emergency medical services as warranted in the course of my participation in Rebounders Gymnastics, Inc. activities. I further authorize the above designated to execute that consent required in connection with such advice or treatment. I hereby release said persons from and agree to indemnify them against any liability arising out of the exercise of the authority here granted.

I understand that the consent and authorization herein granted does not include major surgical procedures, unless necessary to save the individual's life. This consent is valid for one year from the date indicated below. A Xerox, Photocopy, or carbon copy of this authorization shall be considered as effective and valid as the original. I understand that I will be contacted as soon as possible in the event that my child is brought to the hospital for treatment. If I am not available, please contact:

Emergency contact: \_\_\_\_\_ Relationship to  
Camper \_\_\_\_\_  
Phone # \_\_\_\_\_

I also consent to the release of a report containing diagnosis and other medical information related to the examination and treatment of the above patient to such agencies, including insurance companies, as might be considered with payment of charges for hospital services.

\_\_\_\_\_  
Insurance Carrier Policy Number

\_\_\_\_\_  
Name of person holding the policy

\_\_\_\_\_  
Signature of Parent/Guardian Printed Name of Parent/Guardian Relationship Date

\_\_\_\_\_  
Address

\_\_\_\_\_  
Home Phone # Work Phone # Cell Phone #

\_\_\_\_\_  
Non Family Witness Signature Phone # Date

REBOUNDERS GYMNASTICS SUMMER SESSION

7-A West Aylesbury Road
Timonium, MD 21093
410-252-3374

CAMP MEDICAL FORM



PLEASE NOTE: The following information must be completed by the camper's parent/guardian.
NO CHILD WILL BE PERMITTED TO ATTEND CAMP WITHOUT PROPER COMPLETION OF THIS FORM
PRIOR TO THE START OF THE SESSION!
(ANY FORMS NOT FULLY COMPLETED WILL BE RETURNED)

Camper's Name \_\_\_\_\_ Girl \_\_\_ or Boy \_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_
Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_ Zip \_\_\_
Home Phone # \_\_\_\_\_ Parent's Work # \_\_\_\_\_ Cell Phone # \_\_\_\_\_ Other \_\_\_\_\_

EMERGENCY INFORMATION

Emergency Contact \_\_\_\_\_ Relationship to Camper \_\_\_\_\_ Phone # \_\_\_\_\_
Physician Name \_\_\_\_\_ Address \_\_\_\_\_ Phone # \_\_\_\_\_



MEDICAL INFORMATION

- 1. Date of Camper's last Physical Exam \_\_\_\_\_
2. Medical Insurance Carrier \_\_\_\_\_ Group # \_\_\_\_\_ Policy # \_\_\_\_\_
3. Insurance Carrier Address \_\_\_\_\_ Phone # \_\_\_\_\_
4. Does the camper have any allergies to medications, food or environment? No \_\_\_\_\_ Yes \_\_\_\_\_ If yes, please list below:
5. Does the camper have any medical or physical restrictions? No \_\_\_\_\_ Yes \_\_\_\_\_ If yes, please specify below:
6. Does the camper suffer from a chronic illness? No \_\_\_\_\_ Yes \_\_\_\_\_ If yes, please explain below:
\*If medication will be required during camp session, medication must be in the original packaging, with original pharmacy prescribing information. A signed medication information form must be filled out before medication can be administered. (Forms are available at camp check-in.)
7. Does the camper have any physical, cognitive, language, social, emotional and/or sensory difficulties? No \_\_\_ Yes \_\_\_ If yes, please explain below:



IMMUNIZATION INFORMATION

- 1. Does the camper attend a public or private pre-school, elementary or secondary school in Maryland?
Yes \_\_\_\_\_ Name of School (required for attendance) \_\_\_\_\_
No \_\_\_\_\_ (If, no, see below) \*\*\*
2. Has the camper received the proper schedule of immunizations and boosters? Yes \_\_\_\_\_ No \_\_\_\_\_ (If no, see below) \*\*\*
3. Date of last tetanus (DTP) immunization: Month \_\_\_\_\_ Year \_\_\_\_\_ (Required for attendance)



\*\*\*If your child does not attend a Maryland school or is exempt from immunizations due to medical contraindications or religious objections, please have the child's physician fill out and sign the MD Department of Health and Mental Hygiene Form 896 (Maryland Immunization Certificate) or a signed doctors immunization schedule. If your child is too young to attend school, is home schooled or attends a school out of state, an immunization form must also be attached

IMMUNIZATION INFORMATION AND/OR CERTIFICATION AND TETNUS INFORMATION IS REQUIRED PRIOR TO THE START OF CAMP, OR YOUR CHILD WILL NOT BE PERMITTED TO ATTEND.

AUTHORIZATION OF PARTICIPATION: To the best of my knowledge the above health history is correct and the individual herein described has permission to engage in all camp activities except as noted. I understand that falsification of any health-related information will result in the immediate dismissal of my child from camp.

AUTHORIZATION OF TREATMENT: I hereby give my permission to the medical personnel selected by the camp director to order treatment, x-rays, routine test and/or necessary transportation for my child. In the event an authorized individual can not be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure, recommend or administer treatment, including hospitalization for my child, if necessary.

Parent/Guardian Name (print) \_\_\_\_\_ Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_