San Diego Family Science Camp
Medical Release Form

Please complete this form and email to info@familyscience.org. **By signing this form, the participant affirms having read it.**

Child's Name

Child's First Name Child's Last Name

Primary Contact: Parent or Guardian

Name: Address:

Primary Phone:

Alternate Phone: Other

Secondary Conact: ◯ **Parent/Guardian** ◯ **Other**

Name: Primary Phone:

Alternate Phone:

Primary Insurance Company Primary Group/Policy#

Family Physician Name Physician Phone

For the questions below, provide us with relevant medical information **or** check the box indicating "None" if applicable.

Please elaborate on any medical conditions of which we should be aware: None ☐

Any medications currently being taken: None ☐

Any allergies: None ☐

If, during the camp's activities, my son/daughter develops a medical condition or is injured and requires urgent attention, I hereby ☐ **authorize** you to obtain emergency medical/dental care. I will assume financial responsibility for the bills incurred thorugh my insurance company.

Signature: _____ Date: 01/01/01

Parent/Guardian

Or

I ☐ **do not authorize** emergency medical/dental care for my daughter/son.

Signature: _____ Date: 01/01/01

Parent/Guardian