



Transracial Journeys

Exploring race, adoption, and identity in a family setting

FAMILY EMERGENCY MEDICAL FORM

BRING TO CAMP

DO NOT MAIL

PARENT/LEGAL GUARDIAN INFORMATION: (Please Print)

NAME			MOBILE PHONE #()		
LAST	FIRST	MIDDLE	ALTERNATE PHONE # ()		
RELATIONSHIP TO CAMPERS:					
ADDRESS					
CITY			STATE		ZIP
EMERGENCY CONTACT NAME:			TEL:		

INSURANCE INFORMATION: (Please Print)

PLEASE FILL OUT INFORMATION BELOW OR ATTACH A COPY OF THE FRONT AND BACK OF THE INSURANCE CARD. ALSO, IF YOU HAVE A PRESCRIPTION CARD, PLEASE ATTACH A COPY OF FRONT AND BACK.

INSURANCE HOLDER'S NAME:	INSURANCE COMPANY NAME

INDIVIDUAL CAMPER'S INFORMATION: (Please Print; include all adults and children)

Name:		Date of Birth: / /	
Age:	Height:	Weight:	<input type="checkbox"/> Male <input type="checkbox"/> Female
<input type="checkbox"/> address same as above		If not same as above, please provide info below.	
<input type="checkbox"/> insurance coverage same as above			
Please list any known allergies or health conditions requiring treatment, restriction, or other accommodation while on site:			

INDIVIDUAL CAMPER'S INFORMATION:

Name:		Date of Birth: / /	
Age:	Height:	Weight:	<input type="checkbox"/> Male <input type="checkbox"/> Female
<input type="checkbox"/> address same as above		If not same as above, please provide info below.	
<input type="checkbox"/> insurance coverage same as above			
Please list any known allergies or health conditions requiring treatment, restriction, or other accommodation while on site:			

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<input type="checkbox"/> address same as above <input type="checkbox"/> insurance coverage same as above		If not same as above, please provide info below.	
Please list any known allergies or health conditions requiring treatment, restriction, or other accommodation while on site:			

PARENT/GUARDIAN AUTHORIZATIONS:

I, as the parent or guardian of the above listed campers, authorize the above persons attending camp and participating in all activities unless otherwise specified. I understand that I am responsible for supervising my children during all unprogrammed time. I accept the conditions stated on behalf of myself and my children, and hereby release the staff and volunteers of Transracial Journeys from any and all liability in case of accident/injury to myself or my children.

I agree to the release of any records necessary for treatment, referral, billing or insurance purposes for the campers named on this health form. IN CASE OF MEDICAL ILLNESS OR INJURY, I hereby give permission to the staff or volunteers of Transracial Journeys and/or Laurelville to obtain proper medical care for the campers named on this health form. I authorize the certified first aid care provider to give first aid care, medicine, or treatment as necessary and understand that this person is not a medical professional.

Signature: _____ **Date:** _____

Signature: _____ **Date:** _____

PHOTO RELEASE/AUTHORIZATION:

I grant permission to Transracial Journeys to use images of me and/or my minor child/(ren) for the purposes of promoting Transracial Journeys services, programs and special events. I understand that photographs, slides, videos, or digital images may appear in publications or other printed promotional pieces, slide shows, displays, videos, on signs or Transracial Journeys' website for the purpose of promoting the mission and services of Transracial Journeys.

Signature: _____ **Date:** _____

Signature: _____ **Date:** _____