

This consent form gives permission to seek medical attention when deemed necessary, and releases Bluestone Camp & Retreat and its staff of any liability against personal losses of named child.

I/We the undersigned have legal custody of the child named above, a minor, and have given our consent for him/her to attend events being organized by Bluestone Camp & Retreat. I/We understand that there are inherent risks involved in any ministry or athletic event, and I/we hereby release Bluestone Camp & Retreat, its employees and volunteer workers from any and all liability for any injury, loss, or damage to person or property that may occur during the course of my/our child's involvement. In the event that he/she is injured and requires the attention of a doctor, I/we consent to any reasonable medical treatment as deemed necessary by a licensed physician. In the event treatment is required from a physician and/or hospital personnel designated by Bluestone Camp & Retreat, I/we agree to hold such person free and harmless of any claims, demands, or suits for damages arising from the giving of such consent. I/We also acknowledge that we will be ultimately responsible for the cost of any medical care should the cost of that medical care not be reimbursed by the health insurance provider. Further, I/we affirm that the health insurance information provided above is accurate at this date and will, to the best of my/our knowledge, still be in force for the child named above. I/we also agree to bring my/our child home at my/our own expense should they become ill or if deemed necessary by the Camp Director.

Parent/guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Physical Examination

To be filled out and signed by examining physician/examiner

Camper's Name: \_\_\_\_\_ Birth date: \_\_\_\_\_  
Last First Initial

\*Please cite abnormal findings

Height (inches): \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ / \_\_\_\_\_ ( \_\_\_\_\_ / \_\_\_\_\_, \_\_\_\_\_ / \_\_\_\_\_ )

Pulse(s): \_\_\_\_\_

Glasses: \_\_\_ Contacts: \_\_\_ (Wearing \_\_\_) Vision: Right: 20/\_\_\_ Left: 20/\_\_\_ Pupils: Equal \_\_\_ Unequal \_\_\_

Ears/Nose/Throat: \_\_\_\_\_

Lungs: \_\_\_\_\_

Lymph Nodes: \_\_\_\_\_ Skin: \_\_\_\_\_ Heart: \_\_\_\_\_

Abdomen: \_\_\_\_\_ Hernia: \_\_\_\_\_

Other Observations or Concerns:

\_\_\_\_\_

\*I certify that I have examined the above student and I feel this individual may participate in all camp physical activities, except the following:

\_\_\_\_\_

\_\_\_\_\_

Name of examining physician (print please) Physician's address Phone

\_\_\_\_\_  
Signature of examining physician

\_\_\_\_\_  
Date

Effective dates: \_\_\_\_\_ to \_\_\_\_\_

