CHARLESTON COUNTY PARK & RECREATION COMMISSION CAMPS

CAMPER'S NAME _____ **PHONE** _____ **AGE**_____ **DATE OF BIRTH**_____

ADDRESS_____ **CITY**_____ **STATE**_____ **ZIP**_____ **SEX**_____

Legal Guardian_____ Relationship_____ Phone_____ Phone_____

Legal Guardian_____ Relationship_____ Phone_____ Phone_____

OTHER PERSONS AUTHORIZED TO PICK UP YOUR CHILD:

Name_____ Phone(s)_____

Name_____ Phone(s)_____

PLEASE READ AND FILL-OUT THIS FORM FOR THE ABOVE CHILD AND RETURN IT TO CCPRC. THIS FORM MUST BE ON FILE TO PARTICIPATE.

PART I: AGREEMENT TO PARTICIPATE AND HOLD HARMLESS

In agreeing to participate in a Charleston County Park & Recreation Commission (CCPRC) program, course or trip, I recognize certain risks and dangers exist. These risks include, but are not limited to loss or damage of personal property, injury or fatality due to tripping over roots, falling from heights, drowning, allergic reactions to foods or insects, exposure to temperature extremes or inclement weather, sunburn, and vehicle accidents while traveling to and from the activity site.

I understand Charleston County Park and Recreation Commission, its staff and other program participants shall assume no responsibility or liability for me for accident, illness, injury, or loss or damage of personal property caused either by negligence or risks inherent in the activity. I acknowledge and assume all risks in connection with this activity, and I hold CCPRC and its agents harmless from any and all liability, action, claims, and damage of every kind.

Furthermore, I hereby grant permission to all of the foregoing to use any photographs, motion pictures, recordings, or any other record of this event for any legitimate purpose.

PART II: AUTHORIZATION FOR EMERGENCY MEDICAL CARE

I am aware of my child's general condition and affirm that he/she is fit to participate in any activities required for participation in this program. I will fully disclose any relevant medical information on this form and to CCPRC staff, and will engage in all prescribed activities except for those noted by me and/or by my examining physician. In the event my child is rendered unable to communicate by an emergency or accident, I authorize and request such medical and surgical services as may be necessary, and further agree to accept financial responsibility for same.

PART III: MEDICAL INFORMATION

Your CCPRC program may involve strenuous physical activity. If you have questions regarding your childs health and participation, please consult your personal physician. We ask for the following information to be aware of potential problems and to help you safely enjoy your time with us.
Attach additional pages as needed. **HEIGHT**_____ **WEIGHT**_____ **DATE OF LAST TETANUS SHOT**_____

DOES THE CAMPER LISTED ABOVE HAVE? (PLEASE CHECK THE APPROPRIATE COLUMN)

Yes	No	
_____	_____	**Asthma--If yes, what triggers it?** _____
_____	_____	Diabetes or difficulty maintaining blood sugar
_____	_____	High Blood Pressure
_____	_____	Heart Disease
_____	_____	Are you pregnant?
_____	_____	Dislocations--If yes, which joint(s)?_____
_____	_____	Back Problems
_____	_____	Seizures--If yes, when was your last? ___/___/___ How often do they occur?_____
_____	_____	Are you currently taking medication? If yes, what type?_____
		Please list any side effects (fatigue, sensitivity to sun, etc.):_____
_____	_____	Are you allergic to any medications, insect bites/sting, and/or foods? Please list:_____
		If yes, what happens & do you carry medication?_____
_____	_____	Has a physician or health care provider *recently* restricted your physical activity?--If yes explain:_____
		_____

Please include detail about any medical information that you checked YES for **or** other information that may be relevant to staff, EMS or hospital staff:
_____

Optional information
Insurance Company*_____ Group Number*_____ Policy Holder's Name* _____

PreferredPhysician*:_____ Preferred Hospital*_____

My signature on this document is also intended to bind my heirs, representatives, executors, or administrators.
PARENT/GUARDIAN'S SIGNATURE_____ **DATE**_____

ANYONE WITH SEVERE ALLERGIES TO FOOD, PLANTS OR INSECTS MUST INFORM CCPRC STAFF, BRING THEIR OWN MEDICATION, AND BE ABLE TO SELF-ADMINISTER IT!

Participant's Name: _____ Date of Birth: _____
Program Title: _____ Program Date: _____