

**ARKANSAS INTERFAITH CHOIR CAMP  
2025 MEDICAL RELEASE FORM**

One form per camper. This form must be completed for admission to camp.

The undersigned, being the parent, or legal guardian, of (camper) \_\_\_\_\_ whose date of birth is \_\_\_\_\_, authorizes any necessary medical treatment of this camper during the time in which he/she is participating in AI Choir Camp from July 20- 26, 2025. I guarantee payment of all charges incurred during the course of said medical treatment (physician, hospital, x-ray, lab, medication, ambulance, etc.). All medical information will be considered confidential and will be used in confidence and only as needed by physicians, nurses, and their delegates. All information will be destroyed after the completion of Choir Camp.

PRINT THE NAME OF THE PERSON SIGNING

(print) \_\_\_\_\_ (Parent/legal guardian)

Signature \_\_\_\_\_ Date \_\_\_\_\_

Relationship to camper \_\_\_\_\_ Email \_\_\_\_\_

Home phone \_\_\_\_\_ Daytime phone \_\_\_\_\_

Emergency contact person (other than above) \_\_\_\_\_ Phone \_\_\_\_\_

Health Insurance \_\_\_\_\_ Phone \_\_\_\_\_

ID# \_\_\_\_\_ Group# \_\_\_\_\_

Please bring photocopies to camp:

1. Insurance card (front and back)
2. Most recent immunization record
3. Most recent physical exam

Please check any that apply, and provide details on the back\*:

Food or Drug Allergies\* [ ]    Special Diet\* [ ]    Other Conditions\* [ ]

Takes Medication\* [ ]    Has Any Limitations\* [ ]

Campers must leave any over-the-counter and prescription medications with the camp nurse during camp registration. The camp nurse or designates will store and administer all over-the-counter and prescription medication during camp.

Family physician (print) \_\_\_\_\_ Daytime Phone \_\_\_\_\_

Camper: Age as of July 1, 2025 \_\_\_\_ Sex \_\_\_\_ Height \_\_\_\_ Weight \_\_\_\_ Last tetanus shot \_\_\_\_\_  
MM / YY

My camper is fit for FULL [ ] or LIMITED [ ] camp life.

Parent SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_