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**Health Information and Permission Form**

**1069 FFA Circle Road, North Myrtle Beach SC 29582**

Organization or Chapter Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade Completed (as of June) Birth Date Gender

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Full Name Spouse’s Name

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I hereby affirm that my child's bags do not contain any of the following items: weapons, knives of any kind, nicotine in any form, controversial clothing, cigarettes, vapes, or e-cigarettes. Any items brought to camp are subject to random searches.

Parent/Guardian Full Name & Signature

**MEDICAL HISTORY** (Please mark all of the following that apply to this camper)

¤ Contacts/Glasses

¤ Hard of Hearing/Deaf

¤ Recent Head, Back, or Neck injury

¤ Seizure Disorder

¤ Asthma

¤ Existing Heart Conditions

¤Diabetes

¤ Skin Conditions

¤ Joint Problems (recent or chronic)

¤ Previous Hospitalizations or Surgeries

¤ Chronic or Recurring Illness (not previously listed)

¤ Emotional, Social, Learning, or other Mental Health Concerns (ADHD, Anxiety, Depression...)

¤ Activity Restrictions

¤ Other Concerns not previously listed If 'Yes' to any of the above, please explain:

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Any medications to be administered at camp? Name of medication, times and dosage required:

\*Make sure All medications are in original packaging or prescription bottles.

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Check All that Apply to Participant:

¤ Allergies (non life-threatening environmental, medication, food)

¤ Severe or life-threatening FOOD allergies\*

¤ Other Severe or life-threatening allergies Please list the allergen and describe the allergic reaction, and please provide explanation of child’s dietary restrictions.

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Please provide any additional information that we should know about the participant:

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EMERGENCY CONTACTS (provide 2 emergency contacts)

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Name of Insurance Provider \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Claims Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder's DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INSURANCE COVERAGE INFORMATION: All campers attending the SC FFA Leadership Center Overnight Camps are covered under the camp’s insurance program while attending camp activities for any injuries directly related to activities. A copy of the coverage policy can be made available upon request.

\*The most recent copy of the participant’s physical will also be accepted in lieu of an examination.

**Health Care Recommendations by Licensed Physician, Physician’s Assistant, or Registered Nurse**

I have examined the above camp applicant. Date Examined:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Licensed Healthcare Professional’s Name (Printed) Licensed Healthcare Professional’s Name (Signature)

In my opinion, the above’s condition **does** / **does not** preclude his/her participation in an active camp program. (Please circle one.)

Height Weight Blood Pressure

The applicant is under the care of a physician for the following condition(s):

COVID/COMMUNICABLE DISEASE RELEASE: I acknowledge that I freely chose to attend the events at SC FFA Center. I understand that The SC FFA Center has taken reasonable precautions to protect parents, students, administrators, staff, and employees from exposure to COVID- 19 and other communicable diseases during this event. I understand that the novel coronavirus (COVID-19) presents inherent risks to my health and/or the health of my child, and regardless of the care exercised by SC FFA Center, those health risks cannot be eliminated. I agree that by attending this event, I will fully comply with all such measures or face ejection from the event. I will abide by social distancing guide lines and wear a face covering when instructed too. I further acknowledge that my attendance may expose me to the risk of exposure to COVID-19 and other communicable diseases in spite of the above measures and I assume any such risk that may arise therefrom. I accept full responsibility for all medical expenses for any death, injuries or exposure I might encounter by reason of my attendance By signing this form, I also hereby release the SC FFA Center, its Board, its Board members, administrators, directors, officers, teachers, employees, agents, assigns, volunteers and Clemson University and its Board of Trustees, (“released parties”) from and against any and all claims, demands, actions, complaints, suits or other forms of liability that any of them may sustain arising out of (a) my attendance at this event, (b) a failure to comply with the measures imposed by the SC FFA Center, (c) a failure to comply with local, state, and federal laws and policies, procedures, and or (d) arising out of any damage or injury caused by myself or my child. I also agree to indemnify and hold harmless the released parties for any loss, liability damage or costs, including court costs and attorney’s fees, and/or judgments.

PHOTO RELEASE STATEMENT: By signing this document, I grant permission to use the photographs taken while attending SC FFA Leadership Center Programs for any legal use. Including but not limited to: publicity, copyright purposes, illustration, advertising, and web content.

MEDICAL RELEASE STATEMENT (please read & sign) This health history is correct and complete as far as I know. I agree that SC FFA Leadership Center, its agents, officers, employees, trustees and volunteers will not be liable for any injury, death, damage and/or loss to myself or my child, and/or anyone claiming on my or my child's behalf, and I further agree to hold harmless, indemnify and defend SC FFA Leadership Center, its officers, staff, agents, employees, trustees and volunteers for and from any and all liability, claims, losses, injuries, expenses, fees and/or damages arising out of any injury, illness or death to myself or my child or property damage during my or my child's attendance at SC FFA Leadership Center. The minor child herein has permission to engage in all camp activities as described on the activities waiver unless otherwise noted on the health information form. While SC FFA Leadership Center has safety protocols in place to manage allergen related issues, I understand that a minor with specific allergies or intolerances has a role and responsibility in the avoidance of the known allergen. I agree to educate my child, who has allergies or intolerances, to ask questions, read labels, or abstain from the substance in question when in doubt. I hereby give permission to the camp to provide basic first aid as authorized by my child's PCP. I give permission to SC FFA Leadership Center to seek emergency medical treatment including ordering x-rays or routine tests. In the event of an emergency, I give permission to the camp to arrange necessary related transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the practitioner selected by the camp to secure and administer treatment, including hospitalization, for my child. I hereby authorize SC FFA Leadership Camp’s health officials to share health information and health history with the other staff members on a need to know basis. This includes the camp director, program directors, and counselors that have the minor in their care. The purpose of this disclosure is for the necessary staff to be prepared in advance for any medical emergencies. I agree to the release of any records necessary for insurance purposes. The health information that may be disclosed will be from the Health Information Form, and Immunization Records. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I also understand that this information is released to aid in the treatment and care of my child.

Parent/Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_