

SCHOOL OF CREATIVE & PERFORMING ARTS

375 GREENWICH STREET; NEW YORK, NY 10013

Medical Release Form: All Campuses

Form due by May 1, 2012

or with application for registrations after May 1

Participant's Name (Please Print): _____ Date of Birth: _____

Parent/Guardian's Name (Please Print): _____

- Please complete the online Health History Form in your personal online account **before** signing the below medical release.
- A copy of participant's health insurance card- front and back- is required with this form.
- Please return only when fully completed with all required information and signatures.

Medical Release: The online Health History provided on the **online account** is correct and complete as far as I know. The person herein named has permission to engage in all camp activities except as noted. I hereby give permission to the camp to provide, seek, and consent to routine health care, administration of prescribed medications, and emergency treatment for me/my child, as may be necessary, including, but not limited to x-rays, routine tests and treatment, and/or hospitalization. I also give permission for the camp to arrange related transportation. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. It is my intention that the camp be treated as acting *in loco parentis* if the person herein named is a minor. Further, it is my intention that the appropriate representatives of the camp be treated as "personal representatives" for the purposes of disclosing protected health information pursuant to the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996. I hereby agree (pursuant to 45 CFR § 164.510(b)) to the disclosure to camp representatives of the protected health information of the person herein described, as necessary: (i) to provide relevant information to the camp representatives related to the person's ability to participate in camp activities; and (ii) in the case of minors, to provide relevant information to the camp representatives to keep me informed of my child's health status. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

****Signature of PARENT/GUARDIAN:** _____ Date: _____

Signature of PARTICIPANT: _____ Date: _____

*Health Care Recommendations by Licensed Medical Personnel

I examined this individual on _____. (Exam must be within 24 months of camp attendance. New exam is not necessarily required.)

BP _____ Weight _____ Height _____

In my opinion, the above applicant [] is [] is not able to participate in an active camp program.

The applicant is under the care of a physician for the following conditions: _____

Recommendations and Restrictions at Camp

Treatment to be continued at camp: _____

Medications to be administered at camp (name, dosage, frequency): _____

Known allergies: _____

Description of any limitation or restriction on camp activities: _____

Additional information for health care staff at the camp: _____

***Signature of Licensed Medical Personnel** _____

Printed _____ Title _____

Address _____

Phone _____ Date _____

* If participant has received a physical within 24 months of camp and his/her pediatrician has signed a similar form for another school/camp/program, we will accept that form in lieu of getting this form signed. ****Parent signature required for all students, even students 18+.**

PLEASE RETURN FORM TO: FAX: (646) 536-8725 / SCAN to EMAIL: ADMIN@SOCAPA.ORG
MAIL: SOCAPA; 375 Greenwich Street; New York, NY 10013