Medical Release Form:

Forms due by May 1, 2019

Early Registration Forms due February 1, 2019

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

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

- Please complete the Health History Form **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 Health History form provided is correct and complete as far as I know. The person herein named has permission to engage in all workshop activities except as noted. I hereby give permission to the workshop 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 workshop 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 workshop 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 workshop 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 workshop representatives of the protected health information of the person herein described, as necessary: (i) to provide relevant information to the workshop representatives related to the person's ability to participate in workshop activities; and (ii) in the case of minors, to provide relevant information to the workshop 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 workshop to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of workshop.

****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 workshop 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 workshop

Treatment to be continued at workshop: _____

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

Known allergies: _____

Description of any limitation or restriction on workshop activities: _____

Additional information for health care staff at the workshop: _____

***Signature of Licensed Medical Personnel**_____

Printed _____ Title_____

Address _____

Phone _____ Date_____

* If participant has received a physical within 24 months of workshop and his/her pediatrician has signed a similar form for another camp/program/workshop, 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: SCAN to EMAIL: stepitupco@gmail.com MAIL: STEP IT UP 5050 Woodman Ave, #17, Sherman Oaks, Ca 91423