

Camp Lawroweld
91 Allen Avenue
Portland, ME 04103
207-797-3760 Office / 207 -797-2851 Fax

Top section to be filled out by a physician. Make sure all information and signatures are provided. Thank you.

PHYSICIAN'S STATEMENT

Employee Name _____

Parent/Guardian Name (if minor) _____

Address _____

City _____ State _____ Zip _____

Date of last Tetanus Booster? _____ Immunizations up to date? _____

Date of last physical: _____ General Appraisal: _____

Allergy: (please specify) _____

List medications, dose and administration schedule: _____

Special Considerations/Medical Notes: (allergies, medications, restrictions, problems, recent injuries, etc.)

I have examined the person herein described and have reviewed his/her health history. It is my opinion that he/she is physically able to work at camp except as noted above.

Physician's Signature _____ Date _____

Print Name _____ Telephone _____

Address _____

EMPLOYEE'S STATEMENT

Insurance Company _____ Policy No. _____

Insurance Company Address _____

EMERGENCY AND LIABILITY RELEASE

Please read carefully and sign below. It is VERY IMPORTANT that this be signed. Your application will be returned if it is NOT signed.

I release the camp, its management, and Northern New England Conference from liability in case of accident or illness and do further indemnify and hold harmless such entities and persons from such claim. In case of a medical emergency, I hereby give permission to the physician selected by the camp director or healthcare personnel to secure proper treatment and/or to hospitalize as deemed necessary. I understand that staff and campers may be photographed, video graphed, and/or interviewed for use in news media, publications, or promotionals. I consent for Camp Lawroweld to use all photographs, quotes, and recordings.

Signature of Employee: _____ Date: _____

Signature of parent/guardian: _____ Date: _____

(Needed if employee is a minor)