

# Health History



Camper's Name: \_\_\_\_\_

If minor-Child's Parent/Guardian Name: \_\_\_\_\_

*Please circle any of the following applicable for this camper:*

ADHD	Drug/Alcohol Use	Motion Sickness
Anxiety	Ear Infections	Nosebleeds
Asthma	Epilepsy/ Seizures	Physical Handicaps*
Autism Spectrum Disorder	Fainting	Pregnancy
Constipation/Diarrhea	Hearing Impairment	Smoking
Depression	Heart Disease/Defect	Other:
Diabetes	Menstrual Cramps	

*\*Please be aware that Evergreen may not be appropriate for individuals with significant physical and/or emotional challenges.*

**Allergies?** (Food, animals, drugs, environmental, etc) Yes/ No (If yes, please list/specify)

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**Please explain in detail any health concerns noted above or other health concerns we should know about:**

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**Vision Problems:** Yes/No  corrected with glasses  corrected with contacts

**Within the past year, has this camper had any operations, hospitalizations or experienced any serious injury?** Yes No If yes, please give date(s) and explain:

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### Authorization for Medical Care

**In the event that the above named participant requires urgent/emergent medical care, I authorize Hosparus staff to secure necessary care on my /my child's behalf. Furthermore, I authorize Hosparus and/or any medical practitioner or provider to render urgent/emergent care as appropriate and necessary.**

**Signature:** \_\_\_\_\_  
(if camper is a minor, parent/guardian signature is required).

**Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

# Camp Evergreen Program Participant Release Agreement



\_\_\_\_\_  
**Participant's Printed Name**

\_\_\_\_\_  
**Participant's Age**

The undersigned consents to the above-named participant's ("Participant") participation in Camp Evergreen (the "Program") and acknowledges and agrees that the goal of the Program is to provide grief education and support to assist Participant in coping with grief in a healthy way.

In the event the Program involves any physical activity, the undersigned agrees it is his or her responsibility to determine Participant's fitness for participation in the Program and such activity. The undersigned will ensure that the Participant's physician is consulted prior to participation in the Program, if necessary.

In consideration of the Participant's participation in the Program, the undersigned releases and discharges Hosparus Inc., its directors, officers, employees, volunteers and agents ("Hosparus") from any and all claims, demands, actions and judgments which Participant had, now has, or may have against Hosparus for any and all known and unknown injury to Participant, both physical and emotional, and any and all known and unknown injury to Participant's property, both real and personal, regardless of whether such injury is the result of any act or omission of Hosparus.

The undersigned acknowledges and agrees that all information from other participants obtained during Participant's participation in the Program must be kept confidential.

The undersigned has read, understands and agrees to the foregoing and has been provided a copy of this Release Agreement.

\_\_\_\_\_  
**Participant's Signature**

\_\_\_\_\_  
**Date**

If Participant is under the age of 18 years or has a legal guardian:

\_\_\_\_\_  
**Printed Name of Parent/Legal Guardian (circle one)**

(Guardian must provide written confirmation of guardianship appointment)

\_\_\_\_\_  
**Parent/Legal Guardian's Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Witness' Signature**

\_\_\_\_\_  
**Date**