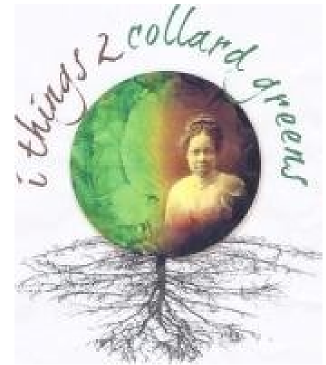
“iThings 2 Collard Greens”

Girls On The Move
Overnight Camp

Medissage Center -Mt. Croghan, South Carolina



July 6th- July 15th, 2023

10 days of Outdoor Fun and Education

Camping, yoga, meditation, gardening, art and crafts, cooking, sewing, knitting, nutrition, green cleaning, and much more

$250.00 Contribution per girl

Information: 202-368-8721/301-455-2607

Email: contact@ithings2collardgreens.org

Website: ithings2collardgreens.org

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WAIVER AND CONSENT FORM

I, the undersigned, hereby certify that I am the parent or legal guardian of

____
Name of Camper

I hereby give permission for the " iThings 2 Collard Greens Camp" staff to seek during the period of the Camp appropriate medical attention for my child, and for my child to receive the medical attention in the event of accident, injury, or illness. I will be responsible for any and all costs of medical attention and treatment.

I hereby acknowledge that my child is physically fit and mentally capable of participating in all camp activities.

I the undersigned, hereby acknowledge and understand that "I Things 2 Collard Greens Camp" is a privately run camp.

I waive, release and forever discharge "iThings 2 Collard Greens Camp" and the aforementioned staffs, officers, agents, employees, representatives, successors and assigns from any and all liability claims, demands, actions, and cause of action whatsoever arising out of or related to any loss, personal injury or property damage that may be sustained or occur during the participation in camp activities or while at Camp.

I give permission for the "iThings 2 Collard Greens Camp" to take photographs of my child while engaged in Camp activities for the sole purpose of advertising and publicity, and I understand that my child's identity will remain anonymous in conjunction with any photograph used in marketing.
My signature below indicated that I have provided true information and have read, understand and agree to all statements on this entire form and on any other form required by the Camp.

Parent/Guardian Signature: ____

Printed Name: ____

Date: ____

EMERGENCY CONTACT INFORMATION

Home Phone #: (   ) ______________________________

Work Phone #: (   ) ______________________________

Emergency Phone #: (   ) __________________________

Contact Name: ____________________________________

Cell Phone #: (   ) ________________________________

Contact Name: ____________________________________

Home Phone #: (   ) ___________________________

Work Phone #: (   ) ____________________________

Emergency Phone #: (   ) _________________________

Contact Name: _________________________________

Cell Phone #: (   ) _____________________________

Contact Name: _________________________________

*Special instructions regarding the care of your child while at camp:

____

____

____

____

INSURANCE INFORMATION

Insurance Company Name: _______________________

Policy #: ___________________   Group #: ____________

Policy Holder's Name: __________________________

Relationship to Camper: _____________________________

*Special instructions regarding Submission of Insurance:

____

____

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SUPPLEMENTAL HEALTH FORM

The Health History and Examination Form must be completed by parents/guardians of minors or by an adult.

Camper's Name_________________________________ Date of Birth _______
Last First Initial
Sex_____ Age ______

Home Address _____________________________________
Street & Number, City, State, Zip

Has this camper been on any medication within the last six months? ________________

If yes, please explain. ________________________________

Has this camper ever required any psychiatric counseling or hospitalization?

Explain ____

Operations or serious injuries (dates) ___________________
Disability or chronic or recurring illness _________________
Activities encouraged or limited by physician ______________
Dietary modifications_________________________________
Other diseases or details of above ______________________
Name of dentist / orthodontist _________________________
Name of family physician _____________________________
Date of last physical examination ______________________
Do you carry family medical/hospital insurance? ___________
If so, indicate: Carrier _______________Policy or Group # __________________

Health History:

(Check, give appropriate dates.)
____ Frequent Ear Infections
____ Heart Defect/Disease
____ Convulsions
____ Diabetes
____ Bleeding/Clotting Disorders
____ Hypertension
____ Mononucleosis
____ Psychiatric Treatment

Diseases
____ Chicken Pox
____ Measles
____ German Measles
____ Mumps

Allergies (dates not needed)
____ Hay Fever
____ Ivy poisoning, etc.
____ Penicillin
____ Other Drugs
____Asthma

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted**.**

Authorization for Treatment: I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine test, treatment and necessary transportation for me/or my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for my child as named above. The completed forms may be photocopied for trips out of camp.

____
Signature of parent or guardian

____
Date