RELEASE FORM

1. MEDICAL RELEASE

All information provided on this form is correct to the best of my knowledge. In case of emergency or illness, I understand that every effort will be made to contact the parent/guardian(s) first and then the Emergency Contact for my child. I give Colorado Christian Service Camp (Camp Como) permission to seek medical treatment for my child in case of emergency. I give Camp Como medical staff permission to provide my child with medical treatment which may include, but is not limited to: the use of acetaminophen (Tylenol), antacids, antibiotic cream, antihistamines (Benadryl, diphenhydramine), ASA (aspirin), Calamine lotion, Cortaid, Dimetapp, ibuprofen (Advil), insect repellent, Pepto-Bismol, Robitussin, Robitussin DM, sting swabs, Sudafed, sunburn spray (Solarcaine), sunscreen, or generic equivalents to these medications, physician consultation, urgent, emergent, and non-emergent medical treatment. I understand that the private health information on this form will only be used and shared for the purposes of medical treatment. I agree to indemnify and hold harmless Camp Como and its leaders, staff, elders, employees, members, agents, vehicle owners, vehicle drivers, trip sponsors, board of trustees, and any other parties volunteering on behalf of the camp from any and all claims, damages, losses, injuries and expenses arising out of or resulting from my child's participation in Camp Como activities. Please note any exceptions to treatment:

Signed: _____ Date: _____
(Parent/Legal Guardian)

2. WAIVER AND RELEASE

I give permission for my child, _____, to attend and participate in activities sponsored by Colorado Christian Service Camp (Camp Como). I understand that these activities are at a high elevation, may include physical activity, and may require transportation. I hereby give my consent for my child to participate in said activities.

3. GENERAL AND COMPLETE RELEASE

In consideration of my child being allowed to participate in activities sponsored by Camp Como, I do, for myself and on behalf of my child, release, forever discharge, and agree to hold harmless Camp Como, its leaders, staff, elders, employees, members, agents, vehicle owners, vehicle drivers, trip sponsors, board of trustees, and any other parties volunteering on behalf of the camp, from any and all liability, claims, damages, suits, fees, and costs incurred by the undersigned and the child that occur while the child is at Camp Como participating in any activity that is sponsored by Camp Como.
_____ (Initial)

I realize that my child may incur personal injury or bodily damage while participating in such activities and acknowledge that many of the activities will be physical in nature and will include travel. I, on behalf of my child, hereby assume all risk of personal injury, sickness, death, damage, and expenses as a result of participating in all activities involved therein. I acknowledge that Camp Como, its leaders, staff, elders, employees, members, agents, vehicle owners, vehicle drivers, trip sponsors, board of trustees, and any other parties volunteering on behalf of the camp, shall be held harmless from any and all actions, claims, costs, expenses, and damages of any kind, growing out of or related to any activity of the camp in which my child participates. I further acknowledge that this is a full and complete release for all injuries, sickness, death, limitations, and damages which my child could sustain as a result of his/her/their participation in any camp activities.
_____ (Initial)

I further agree to hold harmless and indemnify the camp, its leaders, staff, elders, employees, members, agents, vehicle owners, vehicle drivers, trip sponsors, board of trustees, and any other parties volunteering on behalf of the camp for any and all liability sustained by the church and camp as the result of the negligent, willful or intentional acts of my child, including expenses incurred. _____ (Initial)

4. MEDICAL RELEASE AND CONSENT TO EMERGENCY MEDICAL TREATMENT

I authorize the camp and group leader(s) or camp medical personnel, in whose care my child has been entrusted, to consent to any X-ray examination, diagnosis and/or treatment (i.e. anesthetic, medical, surgical, or dental), or hospital care to be rendered to my child under the general or special supervision and on the advice of any physician or dentist licensed under the provisions of the Medical Practice Act on the medical staff of a licensed hospital, whether diagnosis or treatment is rendered at the office of physician or the hospital, I shall be liable and agree to pay all costs and expenses incurred in connection with such medical/dental services rendered. This authority is granted only after a reasonable attempt has been made to contact me or the provided Emergency Contact in a life-threatening situation. _____ (Initial)

5. TRANSPORTATION RELEASE AND WAIVER

I give permission for my child to be transported to and from camp-sponsored activities in a camp, church, staff, volunteer, private, or rental vehicle. I realize there are some dangers involved in transporting children to their activities; therefore, I specifically waive any claims I may otherwise have against the camp, its leaders, staff, elders, employees, members, agents, vehicle owners, vehicle drivers, trip sponsors, board of trustees, and any other parties volunteering on behalf of the camp. Should it be necessary for my child to return home due to the medical reasons, misconduct or otherwise, I shall assume all transportation costs. _____ (Initial)

6. DISCIPLINE RELEASE AND AUTHORIZATION TO RETURN CHILD

In the event of inappropriate conduct by my child, I authorize the group leader or staff to send my child home at my expense from any Camp Como events/activities. _____ (Initial)

7. PERSONAL BELONGINGS RELEASE

I realize that Camp Como is not responsible for my child's personal belongings or lost or stolen items.
_____ (Initial)

8. ELECTRONIC AND PHOTO/VIDEO RELEASE

I give permission to have my child's photograph/video taken at any Camp Como event and to use the photo/video for any of the following, but not limited to: appearance in a video/digital picture to be used in a multimedia presentation or an Internet web page and/or appearance in a picture/video to be used in a publication. _____ (Initial)

I have read and agree to all of the above provisions.

Signed: _____ Date: _____
(Parent/Legal Guardian)

CAMP COMO

Physical Form

Due 2 weeks before camp

P.O. Box 36, Como, CO 80432
Email camp@campcomo.com
Fax 719-836-0461

The COLORADO DEPARTMENT OF HUMAN SERVICES DIVISION OF CHILD CARE mandates that the camper's parent/guardian provide a health history to Camp Como as well as a statement confirming a physical examination has been performed within the preceding 24 months by a licensed physician or a qualified, licensed nurse practitioner demonstrating that the camper is capable of attending camp. Current written authorization from the medical provider for any required prescription or non-prescriptive medicines is mandatory.

Camper Name _____

Dates Attending Camp_____

Church Registered With_____

TO BE COMPLETED BY A DOCTOR OR CNP

Medical conditions Camp Como should be aware of: _____

_____

List any serious illnesses or operations and dates: _____

_____

Special instructions (e.g. dietary restrictions, exempted activities, etc.) _____

_____

Allergies (i.e. drugs, food, other): _____

_____

_____ was given a physical examination on _____/_____/_____.
(Must be within 24 months of designated camp.) S/he is capable of active participation in a regular camp program except as noted above.

Signature of Physician or CNP_____Date_____

Printed Name_____Address_____

Phone (_____)_____City_____State_____Zip_____

CAMP COMO

Medication Form

Due 2 weeks before camp

P.O. Box 36, Como, CO 80432
Email: camp@campcomo.com
Fax: 719-836-0461

Camper Name ___________________________________

Dates Attending Camp ____________________________

Church Registered With ________________________________

NOTES:	CAMP MEDICAL STAFF SIGNATURE:
	X

DOCTOR MUST LIST ALL MEDICATIONS BELOW, *INCLUDING OTC, VITAMINS, HERBS, HOMEOPATHICS, ETC.*

List Rx: e.g. *Claritin D tab*		→		SUN	MON	TUE	WED	THU	FRI	SAT
Med:		CAMP PERSONNEL	8am							
Dosage:			12pm							
Start Date:	End Date:		5pm							
Treatment for:			Bed							
Contra indications:		→	Beginning count of medication =				Ending count of medication =			
		Remaining meds were give to ________________________________ at time of going home.								

PRESCRIBING DOCTOR'S SIGNATURE:

X	Date	Phone ( )		
Printed Name	Address	City	State	Zip

List Rx: e.g. *Claritin D tab*		→		SUN	MON	TUE	WED	THU	FRI	SAT
Med:		CAMP PERSONNEL	8am							
Dosage:			12pm							
Start Date:	End Date:		5pm							
Treatment for:			Bed							
Contra indications:		→	Beginning count of medication =				Ending count of medication =			
		Remaining meds were give to ________________________________ at time of going home.								

PRESCRIBING DOCTOR'S SIGNATURE:

X	Date	Phone ( )		
Printed Name	Address	City	State	Zip

List Rx: e.g. *Claritin D tab*		→		SUN	MON	TUE	WED	THU	FRI	SAT
Med:		CAMP PERSONNEL	8am							
Dosage:			12pm							
Start Date:	End Date:		5pm							
Treatment for:			Bed							
Contra indications:		→	Beginning count of medication =				Ending count of medication =			
		Remaining meds were give to ________________________________ at time of going home.								

PRESCRIBING DOCTOR'S SIGNATURE:

X	Date	Phone ( )		
Printed Name	Address	City	State	Zip

Please use additional forms if necessary.

COLORADO LAW REQUIRES THAT THIS FORM BE COMPLETED FOR EACH STUDENT ATTENDING COLORADO SCHOOLS

Name_____ **Date of Birth** _____

Parent/Guardian _____

COLORADO DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT—CERTIFICATE OF IMMUNIZATION

Vaccine		Enter the month, day and year each immunization was given					
Hep B	Hepatitis B						
DTaP	Diphtheria, Tetanus, Pertussis (pediatric)						
DT	Diphtheria, Tetanus (pediatric)						
Tdap	Tetanus, Diphtheria, Pertussis						
Td	Tetanus, Diphtheria						
Hib	*Haemophilus influenzae* type b						
IPV/OPV	Polio						
PCV	Pneumococcal Conjugate						
MMR	Measles, Mumps, Rubella						
Measles	Measles						
Mumps	Mumps						
Rubella	Rubella						
Varicella	Chickenpox			Healthcare Provider Documentation Date		Lab Verification Date	
Vaccines recorded below this line are recommended. Recording of dates is encouraged.							
HPV	Human Papillomavirus						
Rota	Rotavirus						
MCV4/MPSV4	Meningococcal						
Hep A	Hepatitis A						
TIV/LAIV	Influenza						
Other							

THIS SECTION CAN BE COMPLETED BY CHILD CARE/SCHOOL/HEALTH CARE PROVIDER

☐ **A) Child Care Up to Date**
Up to date through 6 months of age for Colorado School Immunization Requirements — Update Signature _____ Date _____

☐ **B) Child Care Up to Date**
Up to date through 18 months of age for Colorado School Immunization Requirements — Update Signature _____ Date _____

☐ **C) Child Care/Pre-school/Pre-K***
Up to date for Child Care/Pre-School/Pre-K for Colorado School Immunization Requirements — Update Signature _____ Date _____

☐ **D) Complete for K–5th Grade**
Up to date for K–5th Grade for Colorado School Immunization Requirements — Update Signature _____ Date _____

* If age 4 years and fulfills Requirements for Pre-School & Kindergarten, check BOTH Boxes C and D.

HAS MET ALL IMMUNIZATION REQUIREMENTS FOR COLORADO SCHOOLS (6TH GRADE OR HIGHER)

Signed _____ Title _____ Date _____
(Physician, nurse, or school health authority)

Name_____ **Date of Birth** _____

Parent/Guardian _____

STATEMENT OF EXEMPTION TO IMMUNIZATION LAW
(DECLARACIÓN RESPECTO A LAS EXENCIONES DE LA LEY DE VACUNACIÓN)

IN THE EVENT OF AN OUTBREAK, EXEMPTED PERSONS MAY BE SUBJECT TO EXCLUSION FROM SCHOOL AND TO QUARANTINE.

SI SE PRESENTA UN BROTE DE LA ENFERMEDAD, ES POSIBLE QUE A LAS PERSONAS EXENTAS SE LES PONGA EN CUARENTENA O SE LES EXCLUYA DE LA ESCUELA.

MEDICAL EXEMPTION: The physical condition of the above named person is such that immunization would endanger life or health or is medically contraindicated due to other medical conditions.

EXENCIÓN POR RAZONES MÉDICAS: El estado de salud de la persona arriba citada es tal que la vacunación significa un riesgo para su salud o incluso su vida; o bien, las vacunas están contraindicadas debido a otros problemas de salud.

Medical exemption *to the following vaccine(s):*

La exención por razones médicas *aplica a la(s) siguiente(s) vacuna(s):*

☐ Hep B ☐ DTaP ☐ Tdap ☐ Hib ☐ IPV ☐ PCV ☐ MMR ☐ VAR

Signed (Firma) _____ Date (Fecha) _____

Physician (Médico)

RELIGIOUS EXEMPTION: Parent or guardian of the above named person or the person himself/herself is an adherent to a religious belief opposed to immunizations.

EXENCIÓN POR MOTIVOS RELIGIOSOS: El padre o tutor de la persona arriba citada, o la persona misma, pertenece a una religión que se opone a la inmunización.

Religious exemption *to the following vaccine(s):*

Exención por motivos religiosos *de la(s) siguiente(s) vacuna(s):*

☐ Hep B ☐ DTaP ☐ Tdap ☐ Hib ☐ IPV ☐ PCV ☐ MMR ☐ VAR

Signed (Firma) _____ Date (Fecha) _____

Parent, guardian, emancipated student/consenting minor
(Padre, tutor, estudiante emancipado o consentimiento del menor)

PERSONAL EXEMPTION: Parent or guardian of the above named person or the person himself/herself is an adherent to a personal belief opposed to immunizations.

EXENCIÓN POR CREENCIAS PERSONALES: Las creencias personales del padre o tutor de la persona arriba citada, o la persona misma, se oponen a la inmunización.

Personal exemption *to the following vaccine(s):*

Exención por creencias personales *de la(s) siguiente(s) vacuna(s):*

☐ Hep B ☐ DTaP ☐ Tdap ☐ Hib ☐ IPV ☐ PCV ☐ MMR ☐ VAR

Signed (Firma) _____ Date (Fecha) _____

Parent, guardian, emancipated student/consenting minor
(Padre, tutor, estudiante emancipado o consentimiento del menor)