

YOUTH MEDICAL/PERMISSION FORM
ONE FORM PER CHILD

Return to Ghost Ranch in Abiquiu / HC77 Box 11 / Abiquiu, NM 87510

Child's Name

I give permission for my child to participate in the Youth Program. I understand that my child will be participating in swimming, field trips in the Ghost Ranch area, ropes courses and overnight campouts (Jr/Sr High); that it is Ghost Ranch policy that my child be in attendance during Youth Programming hours, unless arranged with the staff; that if I have an elementary age child (up to 6th grade), I will drop them off and pick them up in a timely fashion; that I will be held accountable for my child during non-programming hours over the course of the week; that I agree to have my child photographed for Ghost Ranch publicity purposes.

Confidential Medical Information

Person to Notify in Case of Emergency (Not at Ghost Ranch)

Name Relationship

Address

City, State and Zip Code

Phone: Home Work Other

Insurance: You are responsible for any medical expenses and should be covered by your own health and accident insurance. Complete answers are required. Is your child covered by hospitalization and medical care insurance? Yes No

Name of Insurance Company Policy Number

Telephone

Physician's Name

City, State and Zip Code Phone

If your child has any health problems that we should be aware of, please check & describe (use back of page if necessary):

- | | |
|--|---|
| <input type="radio"/> Neck, back or shoulder pain/injury | <input type="radio"/> Diabetes |
| <input type="radio"/> Asthma or breathing problems | <input type="radio"/> Seizures |
| <input type="radio"/> Frequent or unexplained fainting/dizziness | <input type="radio"/> Hypoglycemia |
| <input type="radio"/> Chronic illness or physical infirmity | <input type="radio"/> High blood pressure |
| <input type="radio"/> Vision or hearing impairments | <input type="radio"/> Heart problems |
| <input type="radio"/> Allergy to bee stings | |

Other allergies or medical conditions: _____

Medications My child carries insulin epinephrine

Is your child currently on any other medication?

Please indicate the name, dosage and condition for which they are used.

By signing this form, I give permission for any emergency medical care provided by ambulance or hospital personnel that might become necessary.

Printed Name Date

Required Signature

List Siblings in Youth Program: _____