Reset Form

PARTICIPANT MEDICAL INFORMATION

State Form 56602 (10-18)
INDIANA STATE MUSEUM AND HISTORIC SITES

INDIANA STATE MUSEUM AND HISTORIC SITES CORPORATION
650 West Washington Street
Indianapolis, IN 46204
Telephone: (317) 232-1637
Fax: (317) 234-1724

PARTICIPANT INFORMATION

Participant's Name		
Participant's Birth Date *(month, day, year)*	Participant's Age	Participant's Gender
Physician's Name	Physician's Telephone Number	
Insurance Provider		
Preferred Hospital		

EMERGENCY MEDICAL CONTACTS

List two emergency medical contacts in the event the parent(s) / guardian(s) of the Camper cannot be reached. An Emergency Contact is authorized to pick up the Camper.

Emergency Contact Person 1	Telephone Number	Relationship to Child
Emergency Contact Person 2	Telephone Number	Relationship to Child

MEDICATION INFORMATION

List your Camper's medication(s). Please include the dosage requirements for each medication.

Condition	Medication
Condition	Medication
Condition	Medication
Condition	Medication

ALLERGY INFORMATION

List your Camper's allergies (food, medication, environmental, etc.). Please describe the action plan for each allergy.

Allergy	Medication / Action Plan
Allergy	Medication / Action Plan
Allergy	Medication / Action Plan
Allergy	Medication / Action Plan

Continued on the next page.

GENERAL INFORMATION

List any information that will help us provide the best camp experience to your Child. This may include behavioral information or other needs.

RELEASE AND WAIVER OF LIABILITY

RELEASE. I expressly assume all risk associated with _____ ("Child") receiving medication(s) during participation in the Indiana State Museum and Historic Site Corporation's ("Museum") Program ("Program").

ACKNOWLEDGEMENTS. I authorize Museum employees to administer above-listed medication(s) to my Child in accordance with the dosing requirements and action plan(s) listed on the previous page of this form.

I acknowledge that the Museum is not responsible for dispensing or storing medication(s) not listed on this form, nor is it responsible for administering medication(s) in a way not approved by the parent/guardian.

I acknowledge that I must provide my Child's medication(s) to Museum employees in the original container in which it was dispensed, and that Museum employees may not accept medication(s) not contained within the original container.

HOLD HARMLESS. I expressly agree to hold harmless, release, defend, and indemnify the Museum its subsidiaries, affiliates, directors, officers, employees, and agents from any and all liability and/or claims that I may be entitled to bring arising from administration of medication(s) to my Child during his/her participation in the Program.

By signing below, the Parent / Guardian acknowledges that he/she has read this Release and accepts its terms.

Signature of Parent / Guardian	Parent / Guardian's Printed Name	Date *(month, day, year)*