COLDWATER foundation
Mink Lake Wilderness Camp | Grand Marais MN

Participant Health History/Insurance Form/Emergency Authorization/Photo Release

Participant Name _____ **Birth Date** _____

Home Phone _____ Cell Phone: _____

Home Address _____
Number & Street City State Zip

Parent/Guardian _____ Relationship _____ Home Phone _____

Cell Phone _____ Work Phone _____

Address (if different from above) _____
(Or different during student trip) Number & Street City State Zip

Second Parent/Guardian _____ Relationship _____

Cell Phone _____ Work Phone _____

Address (if different from above) _____
(Or different during student trip) Number & Street City State Zip

Emergency Contact _____ Relationship _____

Address _____
Number & Street City State Zip

Home Phone _____ Cell Phone _____

Work Phone _____

Immunization History: *Are immunizations up to date? Yes* ☐ *No* ☐ *Date of last tetanus booster:* _____

Health History: Height_____ Weight_____ Date of last physical examination _____

Give a brief explanation of the following, if they apply, to assist our medical staff in helping your camper.

Is participant currently under the care of a counselor/therapist? _____ If, yes, please explain:

_____

_____

Any specific activities to be encouraged or limited by physician's advice? _____

Any medical dietary restrictions? _____

Other health related information for program personnel _____

(Female only) Menstrual history normal? _____ Special considerations _____

If applicable, circle & give approximate dates. Give an explanation below.

ADD/ADHD_____Serious Injuries_____

Ear, Nose, Throat Disorder_____Disability or chronic recurring illness_____

Heart defect/disease_____ Suicidal Thoughts/attempts_____

Seizures_____ Orthodontic Appliances_____

Eating Disorder_____ Mononucleosis (w/in past year)_____

Bleeding/clotting disorders_____ HIV/AIDS_____

Hypertension_____ Strep Throat_____

Operations_____ Headaches_____

Sleep Walking_____ Bed Wetting_____

Depression_____ Low Self-esteem_____

Diabetes_____Asthma (does your child use a peak flow meter?)_____

ALLERGIES (Circle and give an explanation): Poison Ivy_____

Insect Stings _____ Drugs_____

Foods_____ Grass, weeds, pollen_____

List current medications and further explanations of circled items above. Attach a separate sheet if necessary.

_____

_____

_____

_____

Parent/Guardian Emergency Authorization

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed activities except as noted. I understand that the health information about my child will be shared on a 'need to know' basis with other Coldwater staff. I hereby give permission to the medical personnel attending to the treatment of my child to order x-rays, routine tests and treatment for my child, and, in the event I cannot be reached in an emergency, I hereby give permission to the attending physician to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for my child as named above. I give permission to the camp to arrange for necessary related transportation for my child. This form may be photocopied for use out of camp.

Signature of Parent/Guardian _____

Witness Signature (Required) _____ Date _____

Photo Release Form

I grant to Coldwater Foundation, the right to take photographs of myself and my family in connection with this Coldwater Foundation event. I authorize Coldwater Foundation, its assigns and transferees to copyright, use and publish the same in print and/or electronically. I agree that Coldwater Foundation may use such photographs of me with or without my name and for any lawful purpose, including for example such purposes as publicity, illustration, advertising, and Web content. I have read and understand the above:

Signature_____ Printed Name_____

Signature, parent or guardian (if under age 18)_____ Date:_____

PARTICIPANT PROOF OF INSURANCE

ALL STUDENTS MUST PROVIDE PROOF OF HEALTH AND ACCIDENT COVERAGE TO PARTICIPATE. PARENT/ GUARDIAN: PLEASE ATTACH A COPY OF BOTH SIDES OF YOUR MEDICAL INSURANCE CARD AND RETURN TO COLDWATER FOUNDATION. **A copy of your Medical Insurance Card must be attached because it will be presented to the Hospital at the time of service. If the information is not attached, the parent/legal guardian will be billed as private pay and will be responsible for the bill.**

STUDENT'S NAME: _____ BIRTH DATE:_____

POLICY HOLDER: _____ Address: _____

DAY PHONE:_____NIGHT PHONE:_____Email: _____

NAME OF INSURANCE COMPANY: _____ PHONE #_____

POLICY#_____ GROUP#_____

ADDRESS WHERE CLAIMS MUST BE SUBMITTED: _____

NAME OF GROUP INSURANCE, NAME OF GROUP: (employer, union of association)_____