Illinois Wesleyan University Camp – 2025
Medical Questionnaire and Permission Form

Parent or Guardian: This form must be completed in order to participate in camp. If we do not receive this medical questionnaire and permission form by registration deadline, your child will not be able to participate in camp activities (the "Program").

Camper's Name: _____

Address: _____

Street City State Zip

Camp Attending: _____ Date of Birth: _____

Father's Name: _____ Mother's Name: _____

Home/Office#: _____ Home/Office#: _____

Cell#: _____ Cell#: _____

E-mail: _____ E-mail: _____

Emergency Contact: _____ Phone #: _____

PHYSICIAN INFORMATION

Physician: _____ Phone #: _____

MEDICAL HISTORY

1. Allergies: (Please List)

Insect stings: _____

Foods: _____

Medications: _____

Other: _____

2. Is your child currently taking any medication? Yes / No (please circle one)

If yes, please explain: _____

3. Other medical information we should be aware of: _____

PERSONAL MEDICAL INSURANCE: I agree to purchase and maintain during the term of the Program personal medical insurance. I further acknowledge that I am responsible for the cost of any and all medical and health services I may require while participating in the Program except for medical costs arising from an injury that I sustain that is the direct result of **Illinois Wesleyan University's,** including its governing board, trustees, officers, employees (in their official and individual capacities), and any students, agents or volunteers acting at IWU's direction (collectively referred to as "Releasees"), gross negligence or intentional misconduct. I understand and agree that Releasees' shall not in any way be responsible for other contingent losses arising from any injury I sustain that is not the result of Releasees' gross negligence or intentional misconduct.

CERTIFICATION OF FITNESS TO PARTICIPATE: I attest that I am physically and mentally fit to participate in the Program and that I do not have any medical record of history that could be aggravated by my participation in the Program. I further attest that I am physically and mentally fit to participate in the Program, and that I am responsible for consulting with my health care provider towards this end.

RESPONSIBILITY FOR REPORTING INJURIES: I acknowledge that I must be an active participant in my own healthcare and as such, it is my responsibility to report all injuries and illnesses, including signs and symptoms of concussions, to the Program director. I hereby affirm that I have fully disclosed in writing any prior medical conditions and will also disclose any future conditions to the Program director.

PARENTAL PERMISSION: I give my permission for such medical care as may be deemed necessary for my child by the camp medical staff, Advocate BroMenn Hospital medical staff, or any other medical personnel. I understand that any health care facility will make every reasonable effort to contact me first, time and conditions permitting. I agree to be responsible for all charges incurred.

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Parent Name: _____ Parent Signature: _____

(Please print) (Date)