



# HOPE ABOUNDS CANCER NETWORK

## CAMP HOPE Family Weekend Retreat August 15-18, 2024

### MEDICAL RELEASE

This child is an applicant for attendance to Hope Abounds Cancer Network, Camp Hope Family Retreat. We ask that you answer the following questions, helping us to know the current condition of the children. This information will be used for Camp Hope's medical staff and emergency providers during the child's time at Camp Hope.

Child's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_ Male \_\_\_ Female Weight: \_\_\_\_\_

Diagnosis (All): \_\_\_\_\_

\_\_\_\_\_

Recent Surgeries:\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Allergies/Food Restrictions:\_\_\_\_\_

Physical Limitations/Health Problems/Special Needs:\_\_\_\_\_

\_\_\_\_\_

Permission to participate in the following activities:

\_\_\_ Swimming in pool Information that may be relevant to the child's participation at Camp Hope?

\_\_\_ Enjoying beach time

\_\_\_ Exploring forts on Fort Caswell property

Any additional information?

\_\_\_\_\_

\_\_\_\_\_

PHYSICIANS STATEMENT: I hereby verify the above information considers the camper's medical history, health matters, and immunizations. With this knowledge, I approve this child to attend Hope Abounds Cancer Network Camp Hope Family Retreat.

Physicians Signature: \_\_\_\_\_

Physicians Printed Name: \_\_\_\_\_

Physicians Contact Number: \_\_\_\_\_ Date: \_\_\_\_\_