the Fresh Air fund
because a summer can last a lifetime™

THE FRESH AIR FUND
Camp Mariah Session I Weekend
October 25 - 27, 2019

Child's Name:_____Birthday:_____Age:_____Gender:_____

Parent/Guardian:_____

Address:_____Apt #:_____

City/State/Zip:_____

Home Phone:_____ Cell Phone:_____

Alternative Contact:_____ Phone:_____

Email: _____

Health Information (Completed by Parent/Guardian)

Allergies:_____

Food Restrictions:_____

Health Problems:_____

Medications: You must bring **all** the medication your child will need for this trip. All medications **must** be in the **original pharmacy labeled container** with your child's name and the dosage on the label.

Medication Name	Time to be Administered (i.e. Morning or 9pm)	Dosage
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family Doctor or Clinic:_____ Phone:_____

Insurance Plan:_____ Policy Number: _____

Please complete both sides

633 third avenue fl14
new york, ny 10017

EXECUTIVE DIRECTOR Fatima Shama

t 800 367 0003
t 212 897 8900

www.freshair.org

twitter.com/freshairfund facebook.com/freshairfund linkedin.com/company/the-fresh-air-fund instagram.com/thefreshairfund

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Consent & Signature

- I give permission to The Fresh Air Fund to use photos and/or videos of my child and his/her first name in public relations efforts, including, but not limited to print and electronic media and ads, and social media platforms.

- Should my child require medical treatment during his/her participation, The Fresh Air Fund and its Agents have the following permissions:
    - Full authority to take the actions deemed necessary to ensure my child's health and safety, including: delivering routine and ensuring emergency health care; dispensing/administering medication, and seeking medical or dental treatment for my child, if necessary, while s/he is away.
    - To release any medical or other records necessary for treatment, referral, billing, or insurance purposes by The Fresh Air Fund to other medical personnel treating my child.
    - To obtain medical care and treatment as may be deemed necessary for the health and safety of my child by duly licensed physicians, nurses or qualified medical personnel of any hospital, urgent care facility, or clinic.
    - To share my child's health record with duly licensed physicians, nurses, or qualified medical personnel of any hospital, urgent care facility, or clinic.
    - To share my child's health insurance information (medical and/or dental) with any provider of medical services to my child.
    - To use my child's health insurance as the primary coverage for any medical treatment s/he receives while participating in The Fresh Air Fund program(s).

- I acknowledge that:
    - In addition to calls from The Fresh Air Fund's staff and volunteers, information may be sent by email, text, or automated phone calls.
    - My child's health insurance will be the primary coverage for any medical treatment s/he receives while participating in The Fresh Air Fund program, and that I may be responsible for fees for hospital, nursing, medical and surgical services that exceed the amounts covered by my child's health insurance.

Parent/Guardian Signature: _____ Date:_____

Please complete both sides

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