



# Medical Release Form 2026

\_\_\_\_\_ **M / F** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
CAMPER'S LAST NAME CAMPER'S FIRST NAME GENDER BIRTH DATE GRADE IN FALL  
AT BIRTH

## EMERGENCY CONTACT

### PRIMARY

\_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
FIRST NAME LAST NAME RELATION BEST PHONE NUMBER  
\_\_\_\_\_  
ADDRESS CITY STATE ZIP CODE

### SECONDARY

\_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
FIRST NAME LAST NAME RELATION BEST PHONE NUMBER  
\_\_\_\_\_  
ADDRESS CITY STATE ZIP CODE

## MEDICAL INFORMATION

\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_  
CAMPER'S LAST CAMPER'S FIRST NAME OF INSURED RELATIONSHIP TO CAMPER  
\_\_\_\_\_  
CARRIER POLICY NUMBER (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
PHONE NUMBER

### MEDICATION none

All prescribed medication must be in original bottles with original label.

Medication	For?	Day/Time
_____	_____	_____
_____	_____	_____
_____	_____	_____

### ALLERGIES/RESTRICTIONS none

Allergy/Restriction	Reaction
_____	_____
_____	_____
_____	_____

\_\_\_\_\_ (Initial) I give my permission to administer Tylenol/Advil/Allergy relief to above camper as needed.

### CONTACT INFORMATION

Phone: 530-237-2830  
Email: camps@sacnaz.org  
Website: sacnaz.org/district-camps  
Mailing Address: OroNaz Church | 2238 Monte Vista Ave | Oroville, CA 95966