



**DEER RUN RETREAT CENTER**

3845 Perkins Road  
Thompson's Station, TN 37179

**E-mail** Contact@DeerRunRetreat.org  
**Phone** 615-794-2918  
**Fax** 615-794-5123

www.DeerRunRetreat.org  
Camps.DeerRunRetreat.org

**INSTRUCTIONS**

**Group Leader:** Print the 2 pages of the Medical Release Form front/back on one sheet of paper and provide a copy to each participant in your group. Put completed forms in alphabetical order and mail (do not fax) to Deer Run Retreat no later than 7 days before your retreat date.

**Summer Campers:** Complete all information—putting “n/a” if not applicable. Mail completed form (do not fax) to Deer Run Retreat no later than 7 days before the camp start date.

Updated 06/09

**MEDICAL RELEASE FORM**

Please PRINT clearly. All information provided on this form is kept confidential.

Name \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Email Address \_\_\_\_\_

Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Phone  Home  Cell \_\_\_\_\_

Primary Physician \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

In An Emergency Notify \_\_\_\_\_

Relationship \_\_\_\_\_ Phone \_\_\_\_\_

List any physical problems, limitations, major operations, or serious injuries you have had within the last 2 years. Include an explanation if needed. (ex: bone or joint injuries, diabetes or hypoglycemia, back problems, high blood pressure, respiratory problems)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SPECIAL NEEDS**

Please describe special needs so our staff will be prepared. If necessary, please call our office to describe special care or assistance needed.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Fill in the following information or provide a readable copy of your insurance card.

Medical Insurance Company \_\_\_\_\_

Subscriber Name \_\_\_\_\_

Subscriber I.D.# \_\_\_\_\_ Group # \_\_\_\_\_

By completing and signing this form I give Deer Run Retreat Center and/or Deer Run Camps permission to engage medical help for me or my dependent child should an emergency medical situation arise while attending or participating in any event with said organization. I certify that the above information is accurate and complete to the best of my knowledge.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
(parent or legal guardian if a minor)

**PARENT OR LEGAL GUARDIAN OF MINORS:** I give Deer Run Retreat and/or Deer Run Camps permission to administer first aid to my child including over-the-counter drugs for minor headaches or aches, wounds, stings, stomach virus, etc. in case of an illness or accident. [Note: Any allergies to medications should be listed on page 2.]

Signature \_\_\_\_\_ Date \_\_\_\_\_

**PLEASE NOTARIZE IF THE ATTENDEE IS YOUNGER THAN 18 YEARS OF AGE.**

\_\_\_\_\_ sworn to and subscribed before me  
on this the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

Notary Public Signature

My Commission Expires



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# MEDICAL INFORMATION

Please PRINT clearly. All information provided on this form is kept confidential.

Name \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Phone  Home  Cell \_\_\_\_\_

Primary Physician \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

In An Emergency Notify \_\_\_\_\_

Relationship \_\_\_\_\_ Phone \_\_\_\_\_

**DATE OF LAST TETANUS SHOT** \_\_\_\_\_

**LIST ANY DRUG, FOOD, OR INSECT ALLERGIES** \_\_\_\_\_

**LIST OVER-THE-COUNTER MEDICATION(S) THAT CAN BE ADMINISTERED TO A MINOR** (i.e. Tylenol, Ibuprofen, Benadryl, Pepto Bismol)

## CURRENT MEDICATIONS

**List prescriptions or over-the-counter drugs that the person named above will be taking at the time of the retreat or camp.**

**Camps:** Any medications administered by the camp nurse, both prescription drugs or over-the-counter drugs, must be in the original container and must be checked in by the nurse upon camper arrival.

**Please fill in all information for each medication. Please copy this page if more than four medications need to be listed.**

Name of Medication \_\_\_\_\_

Dosage Time (how often or what time the medication is to be administered) \_\_\_\_\_

Dosage Amount \_\_\_\_\_

Prescribing Doctor's Name & Phone Number \_\_\_\_\_

Name of Medication \_\_\_\_\_

Dosage Time (how often or what time the medication is to be administered) \_\_\_\_\_

Dosage Amount \_\_\_\_\_

Prescribing Doctor's Name & Phone Number \_\_\_\_\_

Name of Medication \_\_\_\_\_

Dosage Time (how often or what time the medication is to be administered) \_\_\_\_\_

Dosage Amount \_\_\_\_\_

Prescribing Doctor's Name & Phone Number \_\_\_\_\_

Name of Medication \_\_\_\_\_

Dosage Time (how often or what time the medication is to be administered) \_\_\_\_\_

Dosage Amount \_\_\_\_\_

Prescribing Doctor's Name & Phone Number \_\_\_\_\_