Camp Living Springs Adult Cancer Survivors Retreat
October 16-18, 2020

CAMPER APPLICATION

Please print out and complete "Section 1" and "Section 2" of Camper Application

"SECTION 1" CAMPER APPLICATION

Name: _____

Address: _____City:_____State_____Zip:_____

Telephone: (Home) _____ (Work) _____

Date of Birth: _____Sex: Male _____Female_____

MEDICAL INFORMATION

Type of cancer:_____

Are you currently in treatment for your cancer? Yes ____No____ Date of last treatment: _____

If yes, please specify what kind of treatment you are receiving: _____

_____

List any known allergies: _____

List any medications you are currently taking: _____

The above questions are mandatory. You cannot be considered for Camp Living Springs unless all questions are answered completely.

Required Authorization

I hereby give my informed written consent for the making of still photographs, motion picture films, videotape and sound recordings for use as part of the Morton Plant Mease Cancer Center's public information, educational and training activities. By submitting this application, I authorize Morton Plant Mease to release to the public, including the news media, information regarding the benefits or services the above name received from or through Camp Living Springs adult cancer retreat. This shall include release of name, other identifying information as well as photographs, motion picture films, video tape or sound recordings

It is my understanding that such materials may be used by Morton Plant Mease and its agents for an indefinite period of time unless this authorization is revoked in writing. However, if revoked, Morton Plant Mease shall not be required to recall affected publications, photographs, motion pictures, slides or sound recordings then in use.

Signature: _____

Date: _____

Mail to: Morton Plant Hospital Volunteer Resources
300 Pinellas St., MS 16, Clearwater, FL 33756

Morton Plant Mease
BayCare Health System
VOLUNTEER RESOURCES

October 16-18, 2020
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Please print out and complete "Section 1" and "Section 2" of Camper Application

"Section 2" CAMP LIVING SPRINGS CONSENT FORM

I give my permission for my physician to provide any further necessary information for my participation in Camp Living Springs.

Signature: _____Date:_____

BELOW MUST BE COMPLETED AND SIGNED BY YOUR PHYSICIAN

Patient's Name_____
has medical approval to participate in Camp Living Springs.

The camp weekend scheduled **October 16-18, 2020** will offer a variety of indoor and outdoor activities. Medical personnel will be available throughout the weekend.

The following restrictions apply to my patient (if none, so state).

_____

_____

Physician Signature: _____

Physician Name: (Please Print) _____

Address: _____City, State, Zip: _____

Phone: _____Date:_____

After "Section 1" and "Section 2" are completed, bring or mail to:

Morton Plant Hospital Volunteer Resources

300 Pinellas St., MS 16, Clearwater, FL 33756

For more information call: