

CAMP SUMMERSET - MEDICAL AND TRANSPORTATION FORM

Please be advised that all information on this form will be kept confidential. Answer all the questions, sign, and return with your application.

NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____

PHONE NUMBER: _____ E-MAIL ADDRESS: _____

Is your child allergic to ANY foods or medicine? _____

Is your child allergic to BEE STINGS? _____

Does your child take any medication? _____

(If yes, please provide details)

Any physical activity he/she cannot participate in? _____

Any other important health related information? _____

Persons AUTHORIZED to pick up my child

NAME/PHONE	RELATIONSHIP TO CHILD
1.	
2.	
3.	

Name & Phone # of Doctor: _____

In case of emergency, we can be reached at the following phone numbers: **Please number the order in which to call**

Home: _____ Work: _____ Cell: _____

If I CANNOT be reached, call _____
NAME/PHONE #

Or call _____
NAME/PHONE #

Parents or Guardian Authorization: In case of emergency, if family physician CANNOT be reached, I hereby authorize my child to be treated by "CERTIFIED EMERGENCY PERSONNEL" (i.e. EMT, first responder, ER Physician) YES NO

Parent Signature: _____ Date: _____