PARK DAY CAMP MEDICAL RECORD-2024
PARENTAL INFORMATION
Please submit no later than June 1, 2024 and make a copy of this form for your records.

Campers will NOT be permitted to begin camp until all fees are paid and the camp office has received this medical form!

Camper _____ Birth date ___/___/___ Gender: ☐ Male ☐ Female

Parent(s) or Legal Guardian(s) _____

Home Address _____ City _____ Zip _____

Home Phone: _____ Father's cell: Business Phone: _____ Mother's cell: Business Phone: _____

Grade level as of 8/24 Email address of parent/guardian

Child's Physician _____ Telephone number _____

Child's Dentist _____ Telephone number _____

Is Child under care for a specific illness? ☐ Yes ☐ No Explain _____

Medication taken on a regular basis _____

Health Insurance provider _____ Policy# _____

PLEASE NOTE: ALL MEDICATION IS TO BE SENT TO THE NURSE IN THE ORIGINAL PACKAGING AND UNOPENED WITH YOUR CHILD'S NAME AND INSTRUCTIONS CLEARLY MARK.

Allergies: ☐ No known allergies. ☐ This camper is allergic to: ☐ Food ☐ Medicine ☐ The enviorment (insect stings, hay fever. etc.) ☐ Other
ease describe below what the camper is allergic to and then reaction seen.)

Diet, Nutrition: ☐ This camper eats a regular diet. ☐ This camper eats a regular vegetarian diet. ☐ This camper is lactose intolerant.
This camper is gluten intolerant. ☐ **Other. please explain in space.**

Restrictions: ☐ I have reviewed the program and activities of the camp and feel the camper can participate without restrictions.
I have reviewed the program and activities of the camp and feel the camper can participatee with the following restrictions or adaptions.
(please describe below.)

Two EMERGENCY names, in case parent/guardian cannot be reached, are required.

Name _____ Cellphone _____ Relationship _____

Name _____ Cellphone _____ Relationship _____

*****CONSENT FOR EMERGENCY MEDICAL TREATMENT*****

I do hereby give authority to the Park Day Camp staff to obtain necessary emergency medical treatment for my child with the understanding that the family will be notified as soon as possible.

Signature: _____ **Relationship:** _____

Date: _____ **Phone:** (_____) _____

Complete **only** if your child is taking **any** medication **or** epi pen!

Medication Authorization Form - Physician's Signature Required

Student/Camper Name: _____ Birth Date: _____

Student/Camper Address: _____

Medication: _____ Dosage: _____

Route of Administration and times: _____

Date medication to begin: _____ Date medication to cease: _____

Potential adverse reactions reported by Physician:

_____

_____

Potential adverse reactions for unauthorized user:

_____

_____

Other special instructions:

_____

_____

Physicians Name: _____

*Physician's Signature is required for prescription medication

Signature: _____ Date: _____

Address:

Parent/Guardian Name: _____

Signature: _____ Date: _____

Home Phone: _____Work Phone: _____