MEDICAL FORM

Childs Name: _____ Gender: _____ Age: _____

Personal Physician: _____ Phone: _____

Dentist/Orthodontist: _____ Phone: _____

Insurance Company Name: _____ Policy/Group#: _____

Details of any Allergic Reactions:
_____

_____
_____

Details of serious injuries or operations:
_____

_____
_____

Please specify any other medical condition which we should be aware of and could limit your child's activities:
_____

_____
_____

Dietary Restrictions:
_____

Current Medication:

_____

I hereby state that the above named child is in good health and fully able to participate in all the activities except those which I have mentioned above. In the event of an emergency where I could not be contacted, I hereby give permission to the physician selected by the camp director to hospitalize and/or secure treatment for my child.

_____ _____

Parents/ Guardians signature Date