



CAMPER EMERGENCY CONTACT FORM

Camper Name(s) _____

Contact Information:

Parent or Guardian 1 Name _____

Home Telephone # _____ Cell # _____

Work Telephone # _____ Best Number in an emergency? _____

Parent or Guardian 2 Name _____

Home Telephone # _____ Cell # _____

Work Telephone # _____ Best Number in an emergency? _____

Emergency Contact (In the event we are unable to reach Parent 1 or Parent 2):

Name _____ Relationship _____

Address _____

City, State, ZIP _____

Home Telephone # _____ Cell # _____

Work Telephone # _____ Employer _____

Medical Contact Info:

Doctor Name. _____ Phone # _____

Dentist Name _____ Phone # _____

(continued)

INSURANCE POLICY INFORMATION:

Policy Holder's (P.H.) Name
Address
City/State/Zip
P.H.'s Employer

P.H.'s Date of Birth
Relation
Occupation

Insurance Company
Policy #

Plan #

Does the participant current have any of the following? (If yes, please describe)

Drug allergies:
Food allergies:
Allergies to insect bites:
Special dietary needs:
Asthma:
Frequent headaches:
Dizziness or seizures:

Please list:

Other health problems:

Limitations of activities:

Medications the camper is currently taking*:

***Please note:** If a camper will be taking medication during camp hours, a separate form is required. See Camp Director at drop-off.

Will your son/daughter require any specific treatment for a medical/emotional condition while participating in our program? If yes, please explain. Yes No

IMMUNIZATION DATES:

Please note that you may attach your child's immunization record as an alternative to completing the section below.

DTaP (3 Dates) _____
Meningoccal (1 Date) _____
Hepatitis B (3 Dates) _____
Varicella (1 Date) _____
MMR (2 Dates) _____
Last Tetanus (1 Date) _____
(DPT, TT or TD)
Polio (3 Dates) _____

Parent Signature _____

Date _____

