

COMM CAMP MEDICAL FORM

Child Name: _____ Age: _____ Sex: _____

Address: _____

City: _____ State: _____ Zip: _____

Parent/Guardians: _____

Home Phone: _____ Work phone: _____

Cell Phone: _____ Email _____

Emergency Contact (if above can not be reached): _____

Phone: _____ Relationship to child: _____

Child's Doctor: _____ Phone: _____

Health Insurance Company: _____ Policy Number: _____

Date of last Tetanus Booster: _____

Any known medical conditions? _____ If yes, please list: _____

Is this child currently on any medication? _____

If yes, please list name and dosage of medication (s): _____

Any known allergies (food, plant, medications, bee stings, etc)? _____

If yes, please explain: _____

If a bee stings your child, do you give us permission to give your child Benadryl? ____

If yes, what dosage? _____

Does your child suffer from severe headaches or migraines? _____

If yes, do you give us permission to give your child Tylenol? _____

If yes, what form and what dosage? _____

Do we have your permission to administer emergency First Aid, if needed? _____

Camp directors and head counselors are First Aid/CPR certified

My son or daughter may be transported via ambulance to _____ hospital if emergency care is required. I understand that I will be notified immediately.

I, THE UNDERSIGNED, DO HEREBY DISCHARGE AND RELEASE THE WAVERLY COMMUNITY HOUSE, INC. AND ITS OFFICERS, TRUSTEES, EMPLOYEES, AND VOLUNTEERS FROM CLAIMS FOR INJURIES, LOSSES, OR DAMAGES MY SON OR DAUGHTER MAY NOW OR IN THE FUTURE INCUR WHILE A PARTICIPANT IN A WAVERLY COMMUNITY HOUSE PROGRAM OR EVEN ON THE WAVERLY COMMUNITY HOUSE GROUNDS (INCLUDING FIELD TRIPS).

Signature Parent/Guardian: _____ Date: _____

This must be returned to the Comm Camp office on or before your child's first day of camp.