



name

D.O.B.

CAMPER MEDICAL FORM

Emergency Contact Information

name () _____ relation to you () _____

daytime phone _____ nighttime phone _____

name () _____ relation to you () _____

daytime phone _____ nighttime phone _____

physician 1 _____ physician 2 _____

type of physician () _____ type of physician () _____

phone number _____ phone number _____

Medical Conditions

Pre-existing conditions: _____

Regular medications (list type and dosage): _____

Date of last tetanus shot: _____

I am allergic to:

Food: _____

Medicine: _____

Insects: _____

Other: _____

Treatment used: _____

"I give permission for the above-named child to take part in all Camp Harvest activities both on and off the water unless otherwise restricted in writing, and I absolve Camp Harvest from any injury my child received while attending camp. In case of an emergency, I authorize Camp Harvest to call upon a physician of their choice and to follow his instructions if I cannot be contacted."

signature of parent / guardian

date

