

Additional Family Member Information (Cont.)

Guest Full Name: _____ **Relationship to Primary adult:** _____ **DOB:** _____

1. List any MEDICAL / HEALTH CONDITIONS / RESTRICTIONS for which we should be aware, particularly in case of emergency (Include pertinent past Medical History): _____
2. List any PRESCRIPTION MEDICATIONS: _____
3. List any ALLERGIES and REACTIONS to any medication, food, or environmental conditions: _____
4. List any dietary needs/concerns (ie: Celiac disease, diabetic, peanut/nut allergies, etc): _____
5. List recent (last 12 months) hospitalizations and/or surgeries: _____
6. Physician's Name: _____ Dr's Phone # _____

Guest Full Name: _____ **Relationship to Primary adult:** _____ **DOB:** _____

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Guest Full Name: _____ **Relationship to Primary adult:** _____ **DOB:** _____

1. List any MEDICAL / HEALTH CONDITIONS / RESTRICTIONS for which we should be aware, particularly in case of emergency (Include pertinent past Medical History): _____
2. List any PRESCRIPTION MEDICATIONS: _____
3. List any ALLERGIES and REACTIONS to any medication, food, or environmental conditions: _____
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6. Physician's Name: _____ Dr's Phone # _____

****For Additional Family Members, please make a copy of this form, fill out, and attach prior to mailing.**

EMERGENCY CONTACT: Whom should we contact in case of emergency? (*Must be someone not in attendance at camp*)

Name: _____ Relationship: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Home Ph: _____ Work Ph: _____ Cell Ph: _____

-- PLEASE READ CAREFULLY AND SIGN BELOW --

PARENT/GUARDIAN AUTHORIZATION: To the best of my knowledge, all information provided on this form is accurate and complete. I submit that all persons listed herein are in good health and have permission to participate in all activities, except as noted. In the event I cannot be reached in an emergency, I understand that every effort will be made to contact the emergency person listed. In the event that they cannot be reached, I hereby give permission to the physician and other medical personnel selected by the camp to hospitalize, secure proper treatment for, and to order routine tests and/or injections and/or anesthesia and/or x-rays and/or surgery for myself and/or the persons listed herein. I understand that the Camp Director or health care personnel reserves the right to send a person home whose medical condition, in their opinion, becomes unmanageable and/or places other persons at risk. If I, or any person listed herein, have any changes in health status or condition, I understand that this information will need to be resubmitted.

PRIMARY ADULT NAME: _____ **SIGNATURE** _____ **DATE** _____

(Signature of Spouse and ALL Dependents 18 & over (attach separate sheet with signature if additional space is needed)

Print Name: _____ Signature _____ Date _____

Print Name: _____ Signature _____ Date _____

****PLEASE SEND THIS FORM AHEAD OF YOU TO CAMP****