



MEDICAL EMERGENCY CARD

Please return this card by June 1, 2014

Child's Name _____ Birthdate _____ Age (by 6/1/2014) _____

Address _____ Phone # _____

Parent Name _____ Cell # _____ Work # _____

Parent Name _____ Cell # _____ Work # _____

Physician's Name _____ Phone # _____

IN CASE OF EMERGENCY PLEASE CALL (If parents cannot be reached):

Name _____ Phone # _____ Relation to Child _____

Name _____ Phone # _____ Relation to Child _____

List any allergies (food, drug, insects, etc.): _____

Describe reaction and preferred treatment: _____

List any medications and dosage that your child takes regularly: _____

Does your child have any significant health concerns? Yes No If so, please describe (include treatment): _____

Please list any restrictions or concerns regarding your child and camp activities: _____

May your child be given Tylenol? Yes No Tums? Yes No Benadryl? Yes No

Height (in.) _____ Weight (in.) _____ Medical Insurance _____ Policy# _____

Date of last Tetanus shot: _____ Hepatitis B Vaccine: _____ MMR Vaccine: _____

I verify that (child's name) _____ is up to date on all immunizations.

Physicians Signature _____ Date _____

I give authorized permission to carry out any first aid treatment deemed necessary for the well being of my child.

In an extreme emergency, your child will be transported to the nearest hospital as determined by the Camp Nurse.

Parent Signature _____ Date _____

ALL MEDICAL CARDS MUST BE COMPLETED AND RECEIVED BY JUNE 1, 2014