

DAYCAMP REGISTRATION

Name _____ **Date of Birth** _____ **Sex** _____ **Age** _____
Parent/Guardian _____ **Phone Number** _____
Home Address _____ **Cell Number** _____
_____ **Emergency Number** _____

If not available in case of emergency notify _____ Phone number _____
If not available in case of emergency notify _____ Phone number _____

Session _____

Please return this sheet the first day of the session.

CAMPER MEDICAL FORM
Must be completed for attendance

Name: _____ Date of Birth: ___/___/___ Sex: ___ Age: ___

Parent/Guardian: _____ Phone: _____

Home Address: _____

If not available in an emergency notify:

Name: _____ Phone: _____

Medications: _____

Health History: (check)

Frequent ear infections ___
Heart Defect/Disease ___
Convulsions ___
Diabetes ___
Bleeding Disorders ___
Other ___

Allergies

Hay Fever ___
Poison Ivy ___
Insect stings ___
Penicillin ___
Other Drugs ___
Other ___

Diseases

Chicken Pox ___
Measles ___
German Measles ___
Mumps ___
Asthma ___
Other ___

If other, explain: _____

Chronic or recurring illness/injury: _____

Activity Restrictions: _____

Special Needs: _____

Family Physician: _____ Phone: _____

Immunization History: Date of Basic Immunization Date of Last Booster

Immunization History:	Date of Basic Immunization	Date of Last Booster
Polio		
DTP		
Hib		
Hepatitis B		
MMR		
Varicella Zoster Virus (Chicken Pox)		

Parent/Guardian Signature: _____ Date: _____