

## 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

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

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_