

Colonial Kids Camp Medical Information Form

Contact Information:

Camper's Name _____

Home Address _____ email _____

No & street city state zip

Father Home number (H) _____ Mother (H) _____

Work number (W) _____ (W) _____

Cell number (C) _____ (C) _____

If not available in an emergency, please notify:

Name _____ Phone _____ Relationship _____

Insurance information:

Insurance co: _____ Policy # _____

Policy holder's name (mom/dad) _____

Medical Information:

Medications presently taking: Prescription _____ Non Prescription _____

Drug sensitivities/allergies (circle if severe) _____

Epi-pen: Does your child require an epi pen to treat an allergy? Y N If yes, my child has been instructed to carry their Epi-pen to all camp activities.

Initial _____

Asthma: Does your child use an inhaler for asthma? Y N If yes my child has been instructed to carry their inhaler to all camp activities.

Initial _____

Tetanus: Date of last tetanus _____

Pre-existing conditions:

Does your child have any injuries or conditions that presently exist that would limit her from camp activities?

Y N If yes, describe _____

Has your child been diagnosed with any other significant chronic illness (diabetes, heart, epilepsy, etc?)

Y N If yes, describe _____

The child named above has my permission to participate in the designated Colonial Kids Camp. I understand that camp participation will involve some physical activity which could result in injury. I certify that my child is fully able to participate. I assume all risks to my child's participation and release NYCHAPS and The Folk Art Center and its employees and volunteers from all liability, claim, expenses and actions which may arise from injury or harm to the child as a result of camp participation.

In the event of a medical emergency, I authorize The Folk Art Center to designate a hospital, physician or emergency personnel to provide care (including hospitalization, if necessary) to the child and release the NYCHAPS and The Folk Art Center from any liability for injury or harm which to the child which may result from this medical care. I understand that responsibility for payment of such care medical care will be mine and certify that the child is covered by adequate medical care.

Signed _____ (parent or guardian) Date _____