

**Candlewood Knolls Community
Children's Program Summer Camp**
(One form per child)

Child's Name _____
Summer Address _____
Summer Phone Number _____

Name of Parent(s) or Guardian(s) with whom child resides:

Summer Phone # _____ Cell # _____

Medical Information:

Child's Physician _____

Phone# _____

Date Last Seen _____ Reason _____

Date of Last Tetanus Shot _____

Local

Physician _____ Phone# _____

Current Medical Information:

Child on Medication or have any Physical ailments. Please List ALL.

Child's Known Allergies and Treatment: (*Medications, Food, Tape, Sun block, Insect bites/stings, etc.*)

Pertinent Past Medical History:

- | | | |
|---|-----|--------|
| 1. Has your child been stung by a bee? | YES | NO |
| 2. Permission given for a CKCP Staff member | | |
| A) to apply sunblock, sunburn spray or first aid cream? | YES | NO |
| B) to administer Children's Tylenol in case of severe headache? | | YES NO |
| C) to administer Benadryl in case of Bee sting? | YES | NO |
| D) to give ice pops/candy as treat? | YES | NO |

**Candlewood Knolls Community
Children's Program Summer Camp**

Candlewood Knolls Community Children's Program Summer Camp

Emergency Numbers:

Please give the name, address and phone number of 2 CK residents who should be contacted in the event of an emergency, or to whom your child may be released in case the parents are not available:

Name _____
Address _____ Phone# _____

Name _____
Address _____ Phone# _____

Departure Procedure:

My child has permission to walk home from camp: YES NO

If NO, who will most routinely pick up your child from Camp? _____

Emergency Medical Release:

Please be advised that all campers must carry their own medical coverage. All CKCP staff are first aid and CPR certified and will take whatever emergency medical measures are deemed necessary to assure the safety of each camper. This may include transportation by emergency vehicle to the nearest medical facility. In the event of a medical emergency, you will be notified immediately.

If emergency medical care is deemed necessary and I cannot be contacted, I authorize the staff to act on my behalf in granting permission for my child to receive emergency treatment.

(Signature of parent or guardian)

Date

Please attach copies of Current Insurance or provide us with the following information:

Name of Health Insurance Company: _____

Policy # _____

Subscriber Name _____

Name of Dental Insurance Company: _____

Policy # _____

Subscriber Name _____