Candlewood Knolls Children's Program Summer Camp
2022 MEDICAL FORM
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(One form per child – Please Print Clearly)

Child's Name: _____

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

_____

Summer Address: _____

Summer Phone Number: _____

Cell Phone Number: _____

Medical Information:

Child's Physician: _____

Physician's Phone Number: _____

Date Last Seen: _____ Reason: _____

Date of Last Tetanus Shot: _____

Local Physician Name: _____ Phone Number: _____

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:

(Please circle each answer)

1. Has your child been stung by a bee?	YES	NO
2. Permission given to 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

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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 to 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 Cards or provide us with the following information:

Name of Health Insurance Company: _____

Policy Number: _____

Insurance Company Phone Number: _____

Subscriber Name: _____

Name of Dental Insurance Company: _____

Policy Number: _____

Insurance Company Phone Number: _____

Subscriber Name: _____