Worthington Community Center
Summer Camp Emergency Medical Form

Camp Name: _____

Please print neatly

Participant Information

Participant's Name: _____

Male: ____ Female: ____ Birth Date: ____ /____ /____ Age: ____ Grade Completed: _____

Participant's Street Address: _____

City / State / Zip: _____

Swimming Ability (please check one): Can't Swim ____ Beginner ____ Intermediate ____ Advanced ____

Parent/Guardian Information

Parent Name: _____ Best place to be reached: _____

(H) _____ (W) _____ (C) _____

Parent Name: _____ Best place to be reached: _____

(H) _____ (W) _____ (C) _____

Babysitter/Guardian Name: _____ Best place to be reached: _____

(H) _____ (W) _____ (C) _____

Arrival and Dismissal Information

At the completion of camp each day my child will:

_____ be taken by camp staff to the after camp care program

_____ be picked up by one of the parents or guardians listed above

_____ be picked up by another adult

Name: _____ Phone: _____

_____ has permission to check themselves in and out of camp during arrival and dismissal times.

Please note any **special needs, disabilities, physical conditions, allergies, assistive devices, special accommodations, or auxiliary aids** that the participant may have.

_____

_____

_____

If it is necessary to monitor medication during camp hours, a **Medication Monitoring Form** must be completed as well. Is this necessary for this participant? **YES** _____ **NO** _____

In case of emergency, **please list up to 3 people** who we may contact in case we cannot reach previously listed contacts.

Name: _____ Relationship:_____

Best Phone #: _____

Name: _____ Relationship:_____

Best Phone #: _____

Name: _____ Relationship:_____

Best Phone #: _____

In the event reasonable attempts to contact the authorized persons have been unsuccessful, I hereby give my consent for the administration of any treatment deemed necessary by emergency medical staff.

Preferred Physician: _____ Phone #:_____

Preferred Dentist: _____ Phone #:_____

In the event the preferred physician or dentist is not available, I give my consent to another licensed medical staff, physician, or dentist and the transfer of said participant to this preferred hospital _____ or any other hospital reasonably accessible. This does not cover major surgery unless the medical opinions of two other licensed physicians or dentists concurring in the necessity for such surgery are obtained before surgery is performed.

_____

Parent/Legal Guardian Signature Date

Date Received: _____

Initials: _____