

Required Health Information

Doctor's Name: _____

Doctor's Phone: _____

Dentist's Name: _____

Dentist's Phone: _____

Your Medical Insurance Carrier:

Name of Policy Holder:

Group Number: _____

Policy Holder's No.: _____

List any disability or recurring illness: _____

Note any activities to be limited: _____

Specify any dietary concerns or limitations: _____

Indicate current medication or medical treatment:

Note: All medications sent to camp must be in the original containers and given to the Adult Coordinator.

	Name	Dosage
1.	_____	_____
2.	_____	_____
3.	_____	_____

Note all allergies:

Bee Stings: Aspirin: Penicillin: Peanuts: Other: _____

Immunization Record – Please note the dates of the following immunizations:

DTP:	Tetanus/Diphtheria:	Tetanus:	Varicella (chicken pox):
MMR:	Haemophius Influenza B:	Hepatitis B	Polio:

Please clarify anything else the might help the Day Camp staff regarding your child, especially related to behavioral, physical, emotional, or mental health:

Authorization of Treatment

In the event I cannot be reached, I give permission for the staff of this Day Camp to order X-rays, routine tests and medical treatment for my child until I can be present or involved in the care. I give permission for camp staff to administer medication as listed further on this form

Parent/Guardian Signature _____ Date _____ Please Print Name _____



Mar-Lu-Ridge welcomes all people to a mountaintop experience of Christian community that changes lives, makes disciples, builds friendships and encourages care of God's creation.

For office use:

Fee per person for week of Day Camp: \$ _____

Amount received: \$ _____ Date Received: _____ Balance: \$ _____