

MEDICAL INFORMATION FROM PARENT OR GUARDIAN

Please complete this form and return ASAP to: The Nurse, Episcopal Conference Center, 872 Reservoir Road, Pascoag, RI 02859. **ALL INFORMATION MUST BE COMPLETED AND SENT PRIOR TO REGISTRATION.**

PERSONAL DATA:

Last Name: _____ First Name: _____

Address: _____

City/Town: _____ State: _____ Zip Code: _____

Tel. No.: _____ Birthdate: _____ Age at Camp: _____

CURRENT MEDICAL INFORMATION: (Attach a copy of last physical and immunization record from Doctor)

Has this participant had all currently required immunizations? _____ Yes _____ No

DATE of last tetanus immunization (**must have**) _____

Is the participant subject to any of the following: (**Please indicate yes or no**)

Fainting _____ Yes _____ No Allergies (food, insects, medication, etc.) _____ Yes _____ No

If yes, please state what allergic to _____

Seizures _____ Yes _____ No

Will he/she be taking medication at camp? _____ Yes _____ No If yes, please specify medicine, the condition for which the medicine is prescribed **the dosage, and the times administered.** (Please use back of form if needed.)

• PLEASE NOTE: MEDICATION MUST BE BROUGHT IN PROPERLY LABELED PHARMACY CONTAINERS OR ORIGINAL NON-PRESCRIPTION CONTAINERS. NO MEDICATION MAY BE KEPT WITH THE CAMPER IN THE CABIN.

THE PROGRAM OF E.C.C. involves many physical activities. Has the participant any prior condition, or experienced any illness, injury, or operation, which might interfere with his/her full participation? (Please use back of form if needed.)

_____ Yes _____ No If yes, please describe below:

EMERGENCY INFORMATION:

In case of emergency, while camp is in session, contact as follows:

Custodial parent/guardian: Name _____

Home Phone _____ Work Phone _____ Cell Phone _____

Second parent/guardian: Name _____

Home Phone _____ Work Phone _____ Cell Phone _____

Emergency contact person if neither of the above can be reached: Name _____

Relationship _____ Phone No. _____

AUTHORIZATION FOR TREATMENT OR EMERGENCY CARE:

Consent is hereby given for medical treatment if recommended by the camp nurse or physician and responsibilities for the cost of all such treatment, not covered by insurance policies or paid by insurance companies, is hereby accepted.

Date _____ **Signed** _____

Signature of Parent or Guardian

Insurance Company: _____ Policy No. _____

Name of Policy Holder: _____

Participant's Physician _____ Phone No. _____