

FLOURTOWN SUMMER DAY CAMP

HEALTH FORM

Part I

Family Last Name: _____

Camper's first name (s): _____ Age _____

_____ Age _____

_____ Age _____

_____ Age _____

Address: _____

In the Event of and Emergency:

Primary Contact Person: _____ Relationship _____

Phone (home): _____ Work: _____ Cell: _____

If above person cannot be reached, please contact: Name: _____ Relationship _____

Phone (home): _____ Work: _____ Cell: _____

Family Physician: _____ Phone: _____

Family Dentist: _____ Phone: _____

Orthodontist: _____ Phone: _____

Insurance Coverage

I/We the parent(s) or guardian(s) of the enrolling camper, certify that the camper is covered by adequate medical/hospitalization insurance for the duration of the camp season. I/We understand therefore, that the cost of medical services due to any injuries sustained by the camper will be the financial responsibility of the parent or guardian. The camper enrolled is covered by the following medical/hospitalization.

Name of Insurance: _____ Policy # _____

Group# _____ Parent/Guardian Signature _____

Date: _____

Emergency Coverage

I hereby give permission to the medical personnel selected by the camp director to provide emergency medical treatment. I hereby give permission to the physician selected by the camp director to hospitalize and secure proper treatment for the child mentioned above. This form may be faxed or photocopied. I hereby assume the responsibility for payment for any emergency medical treatment.

Parent/Guardian Signature _____ Date: _____