Salt 'n Light Summer Camp

EMERGENCY MEDICAL INFORMATION

(To be filled out and submitted by all participants)

Participant's Name _____
Last First M.I. Date of Birth

Full Address _____

Home Phone _____ Parent's Email _____

Emergency Contact Person _____
Name Relationship Phone

Health Insurance Company _____

ID/Policy # _____ Group # _____

Parents' Employer: _____

Parents Name: _____

Primary Care Physician _____

Are you taking any medication at present? Y N

If so, please list: _____

Are you allergic to any medications? Y N

If so, please list: _____

Non-prescription medications you do not want to receive _____

Are you allergic to any of the following: ___ Bee stings ___ Food allergies ___ Skin allergies

Do you have a history of any of the following: ___ Diabetes ___ Seizures ___ Asthma

Do you have any current medical or psychological concerns the S'NL Staff should know about? Y N

If so, indicate _____

I give permission for the adult team supervisor to transport and request medical attention for my child.

_____
Signature of participant Parent Signature if participant is under 18

NOTE: The above stated insurance coverage will be applied in all situations requiring medical attention

Please print this form on one page and return to SNL at time of registration