

**Summer Camp 2008**  
**PARENTAL PERMISSION, HEALTH AUTHORIZATION, RELEASE FORM**

Participant's Name: \_\_\_\_\_

Address: \_\_\_\_\_  
City State Zip

Grade Entering Sept. 2008: \_\_\_\_\_ School: \_\_\_\_\_ Birth Date: \_\_\_\_\_

T-Shirt Size \_\_\_ Small \_\_\_ Med. \_\_\_ Large \_\_\_ X-Large

E-mail Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Father: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
First MI Last

Mother: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
First MI Last

Father's pager/cell: \_\_\_\_\_ Mother's pager/cell: \_\_\_\_\_

In Case of Emergency: \_\_\_\_\_ Phone: \_\_\_\_\_  
(Other than Guardian)

Relationship: \_\_\_\_\_

**HEALTH AND MEDICAL INFORMATION**

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Address \_\_\_\_\_  
City State Zip

Medical Plan: \_\_\_\_\_ Plan Number: \_\_\_\_\_

Do you authorize the adult leader to authorize medical treatment for your child in an emergency, as considered necessary by the attending physician?  Yes  No

State any reasons why you do not want medical care given to your child in an emergency: \_\_\_\_\_  
\_\_\_\_\_

List all conditions (such as allergies, seizures) for which your child requires ongoing medication and state the type and frequency of medication given: \_\_\_\_\_

Has your child had difficulty with the following: (please check all that apply)

- Asthma  Fainting Spells  Convulsions  Diabetes  Heart  Eyes  Ears  
 Nose  Throat  Lungs  Digestion  Other: \_\_\_\_\_

List any physical restriction or restriction for any activity on the basis of medical condition: \_\_\_\_\_

Allergy or reaction to any medications?  No  Yes, list: \_\_\_\_\_

Do you authorize an adult leader to administer medications to your child if needed:  yes  no

If yes, please check the medication you will allow the adult leader to administer:

- Tylenol  Ibuprofen (Advil, Motrin, etc.)  Benadryl (or over-the-counter allergy)  
 Prescription Medication Name, Dosage & Frequency \_\_\_\_\_

**(PLEASE COMPLETE THE BACK OF THIS FORM)**