

## Medical/Emergency Information

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Parent/Guardian First and Last Name Phone number

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Parent/Guardian First and Last Name Phone number

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Physicians name Phone number

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Insurance company & policy # Phone number

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Current medications:

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Does your child have: (Circle all that apply)

Epilepsy/Seizure    Diabetes    Celiac Disease    Asthma    Epinephrine Pen

Circle the following applicable allergies:

Bee Sting    Nuts    Dairy    Hay/Straw    Other (please list): \_\_\_\_\_

Please list any other medical concerns:

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Authorizations for my child:

I, the undersigned, hereby give my permission to Citygate Church to contact a physician, emergency squad, hospital, etc. in order to provide emergency care for my child and to provide routine medical care for the above name child should an emergency arise I also give my consent to camp staff to provide over the counter medication for my child

\_\_\_\_\_ Yes \_\_\_\_\_ NO \_\_\_\_\_

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Parent/Guardian Signature Date