



Medical/Emergency Information

Parent/Guardian First and Last Name Phone number

Parent/Guardian First and Last Name Phone number

Physicians name Phone number

Insurance company & policy # Phone number

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Current medications and dose

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

Parent/Guardian Signature Date