

# MEDICAL FORM India

Child's Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_

1. Does your child have any allergies? (Food, medicines, insects, plants, etc.) Y or N

Please explain \_\_\_\_\_

2. Is your child on any regular medication or on a special diet?

Please explain \_\_\_\_\_

3. Does your child have any special medical problems?

Diabetes \_\_\_\_\_ Asthma \_\_\_\_\_ Hyperactivity \_\_\_\_\_ Heart Condition \_\_\_\_\_  
Convulsions/Seizures \_\_\_\_\_ Other \_\_\_\_\_

Please explain \_\_\_\_\_

4. Any restrictions on activity?

Please explain \_\_\_\_\_

5. List any medications to be taken at camp and at what time the medication must be taken.

\_\_\_\_\_

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***Note:** If your child must receive medication during camp, please deliver to the Camp Director in original container with the written instructions. Medication will be administered only according to the written instructions and we cannot administer an expired prescription.*

6. Name of personal physician \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Personal Health/Accident insurance carrier \_\_\_\_\_ Policy Number \_\_\_\_\_

7. Phone numbers where parents can be reached:

Home (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_ Other (\_\_\_\_) \_\_\_\_\_

8. Additional emergency contact: Name \_\_\_\_\_

Phone Number (\_\_\_\_) \_\_\_\_\_ Relationship to Child \_\_\_\_\_

**In case of emergency, I understand every effort will be made to contact me (my spouse or relative). In the event I cannot be reach, I hereby give my permission to the physician selected by the Camp Director to secure proper treatment, including hospitalization, anesthesia, surgery, or medications for my child.**

I have read the above statement and agree to the terms. **I agree**

**I do not agree**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_