



Camper Name _____
 Address _____
 Emergency Contact (Parent or Legal Guardian):
 _____ phone _____
 2nd Emergency Contact (Other than Parent Above):
 _____ phone _____

PARTICIPANT MEDICAL INFORMATION

Name of School Camper Attends _____ County _____

	Y	N	please describe
Does camper have any health concerns or special needs- including physical, psychiatric, or behavioral which may impact the camp day?			
Does the camper have any allergies or dietary restriction we should be aware of? What symptoms would s/he exhibit?			
Is the camper taking any **medication?			

IMPORTANT NOTE REGARDING MEDICATION DURING CAMP:

**** Camp employees may not administer medication. Arrangements must be made for parent/guardian to administer medication/s or for campers to self-administer any medication/s which must be taken during the camp day.**
 ALL medication/s which are administered during Camp require a Medication Order Form signed by the parent and prescribing Physician on file. **You may request forms from the Camp Coordinator (410) 730-3987.**

RECORD OF IMMUNIZATIONS

A copy of the camper's immunization records is required if the camper is **not** enrolled in the Maryland public/private school system. Does the camper have any immunization exemptions because of a parental or guardian objection or medical contraindication? ____ yes ____ no

EMERGENCY MEDICAL INSURANCE INFORMATION

Name of Child's Health Insurance Co. _____
 Subscriber Name _____ ID _____
 Group Number _____ Phone Number _____
 Child's Physician _____ Phone _____
 Child's Dentist _____ Phone _____

AUTHORIZATION FOR MEDICAL TREATMENT

In the event of an EMERGENCY, Parent(s) / Guardian(s) will be contacted as soon as possible. Wilde Lake Community Association/Camp staff will proceed without delay to contact emergency medical personnel for immediate assessment and treatment.

For EMERGENCIES requiring immediate medical attention, I hereby authorize the staff of the Wilde Lake Community Association/Camp staff to have my child _____ transported to Howard County General Hospital and authorize medical treatment if necessary. I further authorize Wilde Lake Community Association/Camp and/or Howard County General Hospital to contact my child's physician and/or dentist (if needed) to obtain medical information for treatment of any emergency medical condition.

I understand, certify, and agree to all of the above:

Signature of Parent / Legal Guardian _____ **Date** _____