

CLARKSTOWN RECREATION & PARKS MINI CAMP MEDICAL/CONSENT FORM

Must be submitted at the time of registration. Save to your PC & e-mail r.metz@clarkstown.org

Camper's Name: _____ Grade: _____

Address: _____

Mini Camp: Winter Mid-Winter Spring

Mother/Guardian Name: _____ Daytime cell # _____

Father/Guardian Name: _____ Daytime cell # _____

Other/Emergency Contact Name: _____ Daytime cell # _____

EMERGENCY/PICK UP INFORMATION:

1. Name: _____ Relationship: _____ Phone: _____
2. Name: _____ Relationship: _____ Phone: _____

MEDICAL INFORMATION:

Doctor's name: _____ Phone: _____

Please list any allergies (bee stings, foods, medications, etc.) _____

Please describe the symptoms of the allergy: _____

Are any medications or precautions necessary for the allergy (i.e. Epi-Pen) _____

Is your child required to take medication or use inhaler during camp hours? ___ YES ___ NO

If yes, please list: _____

Medical comments – limitations for camp activities (i.e. physical, visual, auditory, etc.):

Medication can only be self-administered by the camper due to the fact that there is no RN on location.

Has your child recently been exposed to (in the last six months) to a communicable disease (such as measles, chicken pox or mumps, etc.) YES Date: _____ NO

EMERGENCY/TRIP AUTHORIZATION:

In the event that I cannot be reached and an emergency occurs, I hereby give permission to the physician selected by the Town to hospitalize and secure treatment for my child. I understand that the Town of Clarkstown does not offer accident insurance and that my personal insurance bears primary responsibility in case of an accident. I understand that by signing this form I give permission for my child to attend and travel to all trips. I authorize the use of photos for promotional purposes.

Parent/Guardian Signature (required)

Date