

CAMPER NAME : \_\_\_\_\_ CAMP : \_\_\_\_\_  
Last, First

### CAMPER'S INFORMATION FORM

This form must be completed with all information and signed by parents and camper.

- **BRING THIS FORM TO CAMP WITH YOU!**
- **NO** camper will be able to participate if this form is incomplete.

Home Address: \_\_\_\_\_  
Home Phone \_\_\_\_\_  
Mother's Name \_\_\_\_\_ Daytime Phone \_\_\_\_\_  
Father's Name \_\_\_\_\_ Daytime Phone \_\_\_\_\_  
Mother's Cell Phone \_\_\_\_\_ Father's Cell Phone \_\_\_\_\_

➔ **Emergency Contact - Person to be contacted should parents not be available:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_  
Date of last Tetanus Shot: \_\_\_\_\_ Month / Year. Grade in Sept. \_\_\_\_\_  
Reaction to any medications or drugs \_\_\_\_\_  
Current Medication \_\_\_\_\_

Has camper had (or presently have) any of the following problems: (Indicate Month/Year)

_____ Allergies	_____ Hay Fever	_____ Vision/Hearing Problems
_____ Asthma	_____ Ivy Poisoning	_____ Bleeding/Cutting
_____ Diabetes	_____ Ear Infections	_____ Frequent Headaches
_____ Heart Defect	_____ Seizures/Convulsions	_____ Insect Stings
_____ Other(Explain) _____		

➔ **Insurance Company** \_\_\_\_\_ **Policy No.** \_\_\_\_\_

We hereby authorize the staff of the McBryan Clinic to act for me according to their best judgment in any emergency requiring medical, surgical, dental or emergency services for the camper. The undersigned acknowledges that the below referenced camper has no pre-existing medical conditions, other than those listed on this form, of which the camp should be made aware. We have provided this camper with an adequate supply of medication and allergy serums which he/she will bring to the clinic in original pharmacy containers with doctor's instructions. We agree to indemnify and hold harmless McBryan Clinic and its agents from any injury or damage to property or person resulting from medical authorization to treat the camper or from the treatment itself. Furthermore, we have read, understood and do hereby agree to abide by the McBryan Clinic Rules and Policies as defined by the receipt packet and this form.

➔ **Mother's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Father's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

C  
A  
M  
P  
E  
R  
-  
I  
N  
F  
O  
R  
M  
A  
T  
I  
O  
N  
F  
O  
R  
M