



# 2021 SUMMER DAY CAMP

## MEDICAL ALERT INFORMATION FORM

Child's Name: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

PLEASE PROVIDE A PHOTO OF THE CHILD IF ANY CATEGORY IS CHECKED

Please **CIRCLE** if child carries:  Epipen®  Medical Alert bracelet  Inhaler  Medication

Please indicate if any of the following conditions apply to the child(ren):

- |  |   |
|--|---|
| <input type="checkbox"/> Ear Aches o Seizures            | <input type="checkbox"/> Emotional Concerns |
| <input type="checkbox"/> Attention Deficit (ADD or ADHD) | <input type="checkbox"/> Stomach Aches      |
| <input type="checkbox"/> Skin Conditions                 | <input type="checkbox"/> Arthritis          |
| <input type="checkbox"/> Eating Disorders                | <input type="checkbox"/> Autism             |
| <input type="checkbox"/> Sinus Infections                | <input type="checkbox"/> Nose Bleeds        |
| <input type="checkbox"/> Heart Conditions                | <input type="checkbox"/> Asthma             |
| <input type="checkbox"/> Headaches                       | <input type="checkbox"/> Dietary Needs      |
| <input type="checkbox"/> Diabetes                        | <input type="checkbox"/> Celiac             |
|  | <input type="checkbox"/> Other: _____       |

Please explain extent of health issues checked above and treatments given:

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**ALLERGIES:** If the child(ren) have allergies to any of these categories, please check all that applies:

- Medication \_\_\_\_\_
- Insect stings or bites \_\_\_\_\_
- Animals \_\_\_\_\_
- Seasonal (e.g. hay fever) \_\_\_\_\_
- Foods \_\_\_\_\_
- Other \_\_\_\_\_

Please describe reactions and treatments for any allergies:

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