GoggleWorks Center for the Arts

GOGGLEWORKS SUMMER PROGRAMMING
CAMPER MEDICAL RELEASE

CAMPER NAME:_____ CAMP:_____

PHYSICIAN NAME:_____ PHYSICIAN PHONE NUMBER: _____

WILL YOUR CHILD BE TAKING MEDICATION DURING CAMP? ❑ YES ❑ NO

IF YES, WHAT TYPE OF MEDICATION(S):_____

FOR CAMPERS 13 YEARS AND UNDER TAKING MEDICATION DURING CAMP, MEDICATIONS MUST BE CHECKED IN WITH CAMP STAFF PRIOR TO START OF CAMP. STAFF MEMBERS WILL BE THE ONLY PEOPLE TO ADMINISTER ANY MEDICATIONS TO CAMPERS.

DOES YOUR CHILD HAVE ANY DIETARY RESTRICTIONS OR ALLERGIES? *(…milk, peanuts, bee stings, nuts, food, etc)* ❑ YES ❑ NO

IF YES, PLEASE EXPLAIN: _____

_____

DOES YOUR CHILD HAVE ANY CHRONIC OR RECURRING ILLNESSES? (…asthma, diabetes, seizures, cardiac etc) ❑ YES ❑ NO

IF YES, PLEASE EXPLAIN:_____

_____

PLEASE PROVIDE US WITH ANY OTHER HELPFUL INFORMATION THAT WILL ALLOW US TO SAFELY ACCOMODATE YOUR CHILD:

_____

_____

PARENT/GUARDIAN SIGNATURE REQUIRED FOR EACH ITEM BELOW TO INDICATE PARENTAL CONSTENT:

GOGGLEWORKS HAS MY CONSENT TO OBTAIN EMERGENCY MEDICAL CARE FOR MY CHILD IF NECESSARY.

PARENT/GUARDIAN SIGNATURE_____ DATE_____

GOGGLEWORKS HAS MY CONSENT TO ADMINISTER MINOR FIRST AID PROCEDURES ON MY CHILD IF NECESSARY.

PARENT/GUARDIAN SIGNATURE_____ DATE_____