

FIRST BAPTIST CHURCH
620 Fourth Street
Graham, TX 76450

DAY CAMP

940-549-2360

FOR SEPTEMBER 1, 2009 –DECEMBER 31, 2010

HEALTH AND REGISTRATION INFORMATION

Child's Name: _____ Sex: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Birth Date: _____ Current Grade (completed): _____ Child's Weight: _____

Parent's Name: _____

Are you and your family members of First Baptist Church? _____ If no, are you active in a local church? _____

If yes, where? _____

MEDICAL INFORMATION

Family Physician: _____ Phone: _____

Allergies: _____

Physical disorders: (diabetes, epilepsy, asthma, fainting, heart condition, or other) _____

Has your child been diagnosed hyperactive, ADD, or Learning Disabled? _____

If yes, please give diagnosis and describe treatment and special instructions:

List all medications currently taking: _____

Date of last tetanus shot _____

Can child take part in regular activities including swimming? _____ Swim in shallow end only? _____

EMERGENCY CONTACT INFORMATION

Mother's Name: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Father's Name: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Other Emergency Contact:

Name: _____ Relationship to child: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

MEDICAL TREATMENT AUTHORIZATION

_____ has my permission to engage in prescribed activities, except as noted by me. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by an adult leader in charge, to order injections, surgery, or any other medical and/or dental treatment that me be deemed necessary to insure the well-being of the above named. I also authorize the adult leader (s) in charge to transport my child at their discretion in case of an emergency.

Parent's Signature: _____ Date: _____

Parent's Printed Name: _____

Please attach a copy of your family insurance card

NON-PRESCRIPTION MEDICATIONS

The following non-prescription medications will be available at our first aid station for your child if necessary. Your permission is necessary before any medication can be administered. Any medication you **DO NOT** wish your child to have **SHOULD BE CIRCLED**: **Robitussin** (for cough, congestion, etc.) **Tylenol** (for headache, fever, general aches) **Mylanta** (for upset stomach) **Benadril** (for itching or antihistamine for relief of allergy symptoms)

List any other Medications, (Prescription and Non-Prescription) that you give your permission for your child to take:

Child's Name: _____ has my permission to take the above if deemed necessary by the adult leader in charge of first aid.

Parent's Signature: _____

Date form completed: _____

Please list below additional cell numbers and email addresses.