



# SUMMER CAMP Child(ren) Information Form

**PARENT NAMES:** \_\_\_\_\_

\_\_\_\_\_ *street address, city and state of responsible parent*

\_\_\_\_\_ *responsible parent's e-mail address*

\_\_\_\_\_ *most accessible phone# of responsible parent*

\_\_\_\_\_ *alternate phone number of responsible parent*

## EMERGENCY CONTACT:

\_\_\_\_\_ *name*

\_\_\_\_\_ *relationship*

\_\_\_\_\_ *phone*

\_\_\_\_\_ *name*

\_\_\_\_\_ *relationship*

\_\_\_\_\_ *phone*

\_\_\_\_\_ *name*

\_\_\_\_\_ *relationship*

\_\_\_\_\_ *phone*

## 1. STUDENT NAME: *Tell us about your child...*

\_\_\_\_\_ *Student's name*

\_\_\_\_\_ *Grade entering in the fall*

**Does he/she have allergies? If so, what kind and what is the treatment used?**

No Yes \_\_\_\_\_

**Asthma? If so, what is the treatment plan?**

No Yes \_\_\_\_\_

**Frequent headaches?**

No Yes \_\_\_\_\_

**Near-sightedness? No Yes**

**Glasses or contacts? No Yes**

**Frequent upset stomachs?**

No Yes \_\_\_\_\_

**Are there are conditions that would prevent him/her from participating in outdoor -recess type- activities?** \_\_\_\_\_

**Can your child swim? No Yes**

**2. STUDENT NAME:** *Tell us about your child...*

\_\_\_\_\_  
*Student's name*

\_\_\_\_\_  
*Grade entering in the fall*

**Does he/she have allergies? If so, what kind and what is the treatment used?**

No Yes \_\_\_\_\_

**Asthma? If so, what is the treatment plan?**

No Yes \_\_\_\_\_

**Frequent headaches?**

No Yes \_\_\_\_\_

**Near- sightedness? No Yes**

**Glasses or contacts? No Yes**

**Frequent upset stomachs?**

No Yes \_\_\_\_\_

**Are there are conditions that would prevent him/her from participating in outdoor -recess type- activities?** \_\_\_\_\_

**Can your child swim? No Yes**

**3. STUDENT NAME:** *Tell us about your child...*

\_\_\_\_\_  
*Student's name*

\_\_\_\_\_  
*Grade entering in the fall*

**Does he/she have allergies? If so, what kind and what is the treatment used?**

No Yes \_\_\_\_\_

**Asthma? If so, what is the treatment plan?**

No Yes \_\_\_\_\_

**Frequent headaches?**

No Yes \_\_\_\_\_

**Near- sightedness? No Yes**

**Glasses or contacts? No Yes**

**Frequent upset stomachs?**

No Yes \_\_\_\_\_

**Are there are conditions that would prevent him/her from participating in outdoor -recess type- activities?** \_\_\_\_\_

**Can your child swim? No Yes**