



Please fill out one form per camper. Thank you.

CAMPER _____

Name

Date of Birth (mm/dd/yyyy)

Emergency Contact Name

Phone number:

Does Camper require any special accommodations? Please explain:

ALLERGIES _____

No known allergies

This Camper is allergic to:

Food

Medicine

Other

Please describe below what the Camper is allergic to and the reaction seen:

MEDICAL INSURANCE INFORMATION _____

This Camper is covered by family medical/hospital insurance

Yes

No

Insurance Company

Policy Number

Subscriber

Insurance Co. Phone

HEALTH-CARE PROVIDER _____

Name of Camper's
Primary Doctor(s)

Phone Number