IGDVS Summer Camp Medical Form

Camper Name:_____
(First Name) (Middle Initial) (Last Name)

Date of Birth:_____ **(MM/DD/YY)**

(If Yes, please describe at the provided line below the relevant questions)

Is your child allergic to certain foods? Y/N

_____

Does your child have special dietary requirements? Y/N

_____

Is your child allergic to certain medication? Y/N

_____

Will your child be bringing his/her prescription medicine? Y/N

_____

Does your child have any other medical condition we should be aware of?

_____

In case of emergency, contact:
Name:_____ **Relation to Camper:**_____

Contact Number: (Day)_____ **(Evening)**_____

Physician Name:_____

Physician's Contact Number:_____

I hereby certify that the information here is true and accurate.

Parent Signature: _____ **Date:**_____