



Medical Form Summer Camp Programs

Please fill out this form to the best of your ability with the information requested. We cannot stress enough the importance of providing us with correct names and numbers to use in case of emergency.

Thank you for your cooperation!

Participant's Name: _____ Date of Birth: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Grade in Fall: _____

School Attending: _____ Age (as of June 1): _____

Mother's Name (or Legal Guardian): _____

Mother's Work Phone: _____ Work Hours: _____

Father's Name (or Legal Guardian): _____

Father's Work Phone: _____ Work Hours: _____

Child Lives with Whom: _____

Child's Physician: _____ Phone: _____

Known Medical Conditions of Participant (if any):

Restrictions

Heart Condition or disease YES/NO _____

Diabetes YES/NO _____

Convulsions YES/NO _____

Asthma YES/NO _____

Allergic to medication YES/NO _____

Allergic to insect stings YES/NO _____

Does your child use an inhaler? YES/NO _____

Does your child carry an EPI injector? YES/NO _____

Allergies: _____

Date of last Tetanus shot: _____

Medication(s) participant is currently taking: _____

For Medication(s) Taken During Camp Hours:

Name: _____ Dose: _____ Time: _____

Dispensing & Storage Info.: _____

Possible Side Effects: _____

(continued)

Name: _____ Dose: _____ Time: _____
Dispensing & Storage Info.: _____
Possible Side Effects: _____

Name: _____ Dose: _____ Time: _____
Dispensing & Storage Info.: _____
Possible Side Effects: _____

Name: _____ Dose: _____ Time: _____
Dispensing & Storage Info.: _____
Possible Side Effects: _____

Permission to Dispense Medication:

I understand that it is my responsibility to give the medication directly to program staff with full instructions in individual dosage containers or clearly labeled envelopes. Medication dispensing can only be changed by completing another Medical Form. I understand that staff will not alter dispensing procedures without a new, completed form.

I hereby acknowledge that the above information provided for the dispensing of medication for my minor child, guardian, ward or other family member is accurate. By signing below, I give permission to the staff of the Westmont Park District to dispense the medications listed above, in the dosage listed above. If, after administering the medication, there is an adverse reaction, I give my permission to the staff to secure any treatment deemed necessary by medical personnel for immediate.

Parent/Guardian Signature: _____ Date: _____

Waiver and Release of All Claims:

I recognize and acknowledge that there are certain risks of physical injury in connection with the administering of medication to my minor child. In consideration of the Westmont Park District administering medication to my minor child, I do hereby fully release or discharge the Westmont Park District and its officers, agents, volunteers and employees from any and all claims from injury, damages and losses I or my minor child may have, arising out of , connected with, incidental to, or in any way associated with the administering of medication.

I further agree to indemnify, hold harmless and defend the Westmont Park District and its officers, agents, volunteers and employees from any and all claims resulting from injuries, damages and losses sustained by me or my minor child and arising of, connected with, incidental or in any way associated with the administering of medication.

Parent/Guardian Signature: _____ Date: _____