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: __________________