

MEDICAL WAIVER

Please provide the following medical information for your child:

NAME OF CAMPER _____

**Primary Emergency
Contact**

Name _____

Relationship _____

Phone Number(s) _____

**Secondary Emergency
Contact**

Name _____

Relationship _____

Phone Number(s) _____

Allergies (medications, food, bee sting, poison ivy, etc)

Please describe the nature of the allergic reaction (rash, hives, difficulty breathing, etc.)

Injury History

Medical Conditions

Medications Currently Taking

Date of Last Tetanus Shot

Additional Medical Related Notes

Please return this form with a copy of your medical insurance card (front and back) by June 16, 2008.