



Friends of the Cobbossee Watershed Camp Medical Form

Please send in this completed form no later than one week prior to your child's camp session to:
FOCW
PO Box 5003
Augusta, ME 04332

Camper's Name _____ Male Female Age _____

Height _____ Weight _____ Birth Date _____

Emergency Contact (Parent or Guardian information and back-up contact)

Parent/Guardian Name (Printed) _____

Home Phone _____ Work Phone _____ Cell Phone _____

Alternative (2nd Contact) _____ Relationship _____ Phone #(s) _____

Family Doctor _____ Phone _____

Insurance Provider _____ Group ID# _____

Health History: Check those that apply, give dates and description where appropriate:

- Asthma
- Allergies to Food
- Allergies to Insect Stings
- Allergies to Medication
- Allergies to Plants/Pollen
- Diabetes
- Headaches
- Fainting
- Earaches
- Stomach Upsets
- Contact lenses
- Glasses
- Hearing Impairment
- Behavior/Learning Challenges
- Other _____

Please explain any checked items: _____

Allergy	Reaction	Medication Required

Current Medications	Directions	Reason for Medication	Sent with Participant?
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

All medications will be kept and distributed by FOCW staff. Please include written instructions with medication.

Date of most recent tetanus shot: _____

Dietary Restrictions: _____

Swimming Ability Cannot Swim Can Swim 100 feet Can Swim 500 feet Strong Swimmer

Consent: To the best of my knowledge the above information is correct. In the event of an emergency requiring medical attention, I understand that every effort will be made to contact me (parent or guardian of child named above) before any treatment or hospitalization is undertaken. In the event that I am unable to be contacted regarding such emergency, I hereby grant permission to a physician or other hospital personnel designated by the Friends of the Cobbossee Watershed (Friends) supervisor to attend to my son/daughter. I also give permission for a Friends employee to transport or arrange transportation for my child to the hospital or other appropriate medical office.

Parent/Guardian Signature _____ Date _____