Please send in this completed form no later than one week prior to your child's camp session to:
FOCW
PO Box 206
East Winthrop, ME 04343

Friends of the Cobbossee Watershed
Camp Medical Form

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?**
			❒Yes ❒No
			❒Yes ❒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 _____