

TOWN OF CORNWALL KINDERKAMP

SESSION 1 _____ **2** _____

CHILD'S NAME: _____ DOB: _____ AGE: _____
FIRST MI LAST

ADDRESS: _____
STREET TOWN ZIP

HOME TELEPHONE #: _____

HEIGHT: _____ WEIGHT: _____ EYE COLOR: _____ HAIR COLOR: _____
ANY DISTINGUISHING MARKS/CHARACTERISTICS:

PARENT/GUARDIAN NAME: _____

PARENT/GUARDIAN DAYTIME PHONE # (CELL/WORK) _____

PARENT/GUARDIAN WILL BE CALLED FIRST IN AN EMERGENCY. IF YOU CANNOT BE REACHED PLEASE NAME ANOTHER PERSON TO CONTACT IN ANY EMERGENCY:

NAME: _____ RELATION TO CHILD: _____

DAYTIME TELEPHONE # _____

CHILD'S MEDICAL HISTORY: _____ **PLEASE CHECK ONE OF THE FOLLOWING:**

_____ MY CHILD HAS NO KNOWN MEDICAL CONDITION THAT THE CAMP DIRECTOR AND CAMP MEDICAL STAFF SHOULD BE ADVISED OF.

_____ MY CHILD HAS ONE OR MORE MEDICAL CONDITIONS THAT THE CAMP STAFF SHOULD BE ADVISED OF. *******PLEASE FILL OUT THE NEXT SECTION*******

MY CHILD HAS THE FOLLOWING ALLERGIES: _____

MEDICAL CONDITIONS: (EX: ASTHMA) _____

ANY SURGERY/PROCEDURE STILL REQUIRING DOCTOR SUPERVISION: _____

IF YOU ARE ADVISING THE CAMP STAFF OF ANY MEDICAL INFORMATION PLEASE PROVIDE THE FOLLOWING INFORMATION:

DOCTOR'S NAME: _____ PHONE NUMBER: _____
ADDRESS: _____

DATE

Signature of Parent/Guardian