

The information on this form is required of campers; it is gathered to assist us in identifying appropriate care. In the event of an emergency, this form will be given to the appropriate emergency personnel. Any changes to this form should be communicated to the camp director upon the camper's arrival to RECKids Camp.

**Provide complete information on both pages of the form so that the camp can be aware of your child's needs.**

<b>Camper Information</b>				
CHILD'S LAST NAME	FIRST NAME	MI	DATE OF BIRTH (MM/DD/YYYY)	AGE
HEIGHT	WEIGHT	GENDER	ADDRESS	

<b>Emergency Contact(s)</b> In the case of an emergency, illness, or accident involving the child, the UDCR staff is authorized to contact the following:			
1.)	NAME	RELATIONSHIP TO CAMPER	
	MOBILE PHONE	DAY PHONE	EVENING PHONE
2.)	NAME	RELATIONSHIP TO CAMPER	
	MOBILE PHONE	DAY PHONE	EVENING PHONE

<b>Insurance Information</b>		
Is the camper covered by family medical/hospital insurance?	YES	NO
If so, indicate carrier or plan name	_____	Policy # _____
Name of insured	_____	Relationship to camper _____
<b>Family Physician</b>		
NAME OF FAMILY PHYSICIAN	PHONE	ADDRESS

<b>Please share any additional information about your child's behavior, social skills, and physical, emotional, or mental health of which the camp should be aware:</b>

**PLEASE COMPLETE PAGE 2 OF THIS FORM.**

**Allergies**

Does your child have allergies?      YES      NO      Does your child have asthma?      YES      NO

Please list ALL allergies (i.e., food, latex, insects, plants, medications, other). Include reaction description and management.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Does your child require administration of any prescribed medication in the event of an allergic reaction?      YES\*      NO  
 \*If yes, please fill out the supplemental Medication Administration Authorization Form accordingly.

Does your child require administration of any prescribed medication in the event of any other type of medical emergency?      YES\*      NO  
 \*If yes, please fill out the supplemental Medication Administration Authorization Form accordingly.

**Medications**

Please list ALL medication (including over-the-counter or non-prescription drugs) taken routinely. It is your responsibility to notify camp staff if there are changes in the prescribed medications your child is taking. At no time will any Campus Recreation employee administer medication to your child, unless authorized for emergency purposes according to the Emergency Medical Plan. If your child requires any medication during UDCR's RECKids Camp, you will be responsible for administration of such medication. Additionally, no medications will be maintained on site by UDCR or its employees unless authorized according to the supplemental Medication Administration Authorization Form.

My child takes medications on a routine basis      NO      YES      If YES, my child takes medication as follows:

MED #1	DOSAGE	SPECIFIC TIMES TAKEN EACH DAY	REASON FOR TAKING
MED #2	DOSAGE	SPECIFIC TIMES TAKEN EACH DAY	REASON FOR TAKING

**Immunizations**

Provide the month and year for each immunization. Starred (\*) immunizations must be current. Copies of immunization forms from health-care providers or state or local government are acceptable and must be attached to this form.

Immunization Dose	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Most Recent
Diphtheria, Tetanus, Pertussis (DTaP or TdaP)*						
Tetanus booster (dT or TdaP)*						
Mumps, Measles, Rubella (MMR) *						
Polio (IPV)*						
Haemophilus Influenzae type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (Chicken Pox)						
Had Chicken Pox						

Tuberculosis (TB) Test Date: \_\_\_\_\_ Result:      Negative      Positive

If your camper has not been fully immunized, please sign the following statement: I understand and accept the risks to my child from not being fully immunized.

\_\_\_\_\_  
 CUSTODIAL PARENT/GUARDIAN SIGNATURE

\_\_\_\_\_  
 RELATIONSHIP TO CAMPER

\_\_\_\_\_  
 DATE

**Permission to Provide Necessary Treatment or Emergency Care:**

In the event of a medical emergency requiring more than basic first aid, I understand that all attempts to contact me will be made. I also understand that in order to obtain the quickest medical treatment for my child, UD Campus Recreation will contact EMS and, if necessary, transport my child to the nearest emergency facility. **The information in this Emergency Medical Plan is true and correct as far as I know, and the person herein described has permission to engage in all camp activities except as noted.**

\_\_\_\_\_  
 PRINT NAME OF PARENT/LEGAL GUARDIAN

\_\_\_\_\_  
 SIGNATURE OF PARENT/LEGAL GUARDIAN

\_\_\_\_\_  
 DATE