Emergency Information sheet
Carrboro Recreation & Parks Department
Summer Camp Programs

FORM USE: This form will be used to provide the camp staff with emergency contact information, to provide medical personnel with health related information that could be pertinent in an emergency, Permission to seek medical treatment until we can locate you, and to help us best meet your campers needs. This form is not used as a screening tool.
DIRECTIONS: This is a parent / guardian completed form and is required for participation. Completion prior to camp helps us focus on your campers rather than their forms. Please return to:

Carrboro Recreation and Parks Department
100 N. Greensboro St.
Carrboro, NC 27510

CHILD NAME________________________________AGE________BIRTHDATE________________

NAME OF PARENT / GUARDIAN #1 ____

NAME OF PARENT / GUARDIAN #2 ____

ADDRESS OF PARENT / GUARDIAN #1 ____

____

ADDRESS OF PARENT / GUARDIAN #2 (if different from above)
____

____

HOME PHONE #1 _____________________________ WORK PHONE #1 ______________________

CELL PHONE #1 _____________________________

HOME PHONE #2 (IF DIFFERENT FROM ABOVE) _________________________

WORK PHONE #2_____________________________ CELL PHONE #2 ______________________

CAMP(S) ATTENDING____

A. MEDICAL HISTORY

1. Is child allergic to anything (including food, insects, plants, allergies, medications, etc.)
   Yes____No________ If yes, what____

2. Does child have Asthma_________ Will child have inhaler at camp _______________

3. Any previous diseases, operations, hospitalizations or illnesses that are pertinent to camp?
   Yes___No_____

   If yes, what____

   ____

OVER

4. Any disabilities (developmental, physical, behavioral, emotional) Yes___No___

   If yes describe____
   ____

5. Is child under care of a doctor: Yes____ No_______
   If yes for what reason____
   ____

6. Any history of convulsions: Yes__ No___

7. Any history of heart trouble: Yes__ No___

8. **Any special needs** that we should know about?__________________________________

9. Is your child on any medication? Yes___ No________
   If yes, explain:____

10. Are immunizations up to date? Yes___No____ Date of last Tetanus shot____________________

*** Please note, our staff cannot administer any medications***

B. <u>SPECIFIC PROGRAM INFORMATION</u>

Primary language if not English? __________________________

C. <u>OTHER EMERGENCY INFORMATION</u>

If neither parent (nor guardian) can be contacted please call: (local person please)

1) Name: __________________ Relationship: ___________Phone: ___________ Phone ___________

1) Name: __________________ Relationship: ___________Phone: ___________ Phone ___________

I agree that the operator may authorize the physician of his/her choice to provide emergency care in the event that neither I nor the family physician can be contacted immediately. I further agree that emergency medical assistance may be called immediately if determined necessary by the operator.

____

Signature Date