

## HILL TOP SUMMER CAMP ~ CAMPER EMERGENCY CARD

Camper Name:		Home Phone: (    )	
Date of Birth:	Resides With:	Grade Entering:	
Address:		City, State, Zip:	
<b>Parent 1 Name:</b>		<b>Parent 2 Name:</b>	
Home Phone:		Home Phone:	
Business Phone:		Business Phone:	
Cell Phone/Pager:		Cell Phone/Pager:	
<b>If parent or guardian cannot be reached, please contact:</b>			
1) Name:		2) Name:	
Phone:		Phone:	
Physician:		Physician Phone:	
Dentist:		Dentist Phone:	
Is your child allergic to bee stings?    Yes ____ No ____			
Is your child allergic to any food, drug, or other substance? Yes ____ No ____			
If yes, please list and explain reaction and treatment:			
<b>OVER →</b>			

Please list conditions that require special attention (i.e. asthma, ADD, seizures, diabetes):	
Please list all medications taken in a 24-hour period (including dose and frequency):	
My child wears (please circle)    GLASSES    CONTACTS    HEARING AIDS    OTHER DEVICES (    )	
<b><i>Prescription medication must be dispensed with a note from the Healthcare Provider and parent. Medications must be in original pharmacy labeled bottle with student's name, physician name, date, drug name, dose, and directions for use.</i></b>	
<b><i>Non-prescription medication must be accompanied by a note from a parent. It must be in original labeled package.</i></b>	
<b>I GIVE MY PERMISSION TO ADMINISTER:</b>	
Tylenol / Acetaminophen	Yes ____ No ____
Advil-Motrin / Ibuprofen	Yes ____ No ____
Benadryl	Yes ____ No ____
Tums / Antacid	Yes ____ No ____
I AUTHORIZE SCHOOL ADMINISTRATORS TO MAKE NECESSARY ARRANGEMENTS IN AN EMERGENCY IF I AM UNAVAILABLE BY PHONE, AND TO INITIATE PROPER EMERGENCY MEDICAL SERVICES.	
SIGNATURE OF PARENT / GUARDIAN:	DATE:
Health Insurance Company:	Policy Number: