

CAMP FAIRFAX Emergency Information Form

Please Sign and Return to Camp Staff

Please print: Child Name: _____ Birthdate _____ Male Female

School Attending in Fall of 2019 _____ Grade Entering: _____

Address: _____ # _____ Street _____ Town/City _____ State _____ Zip _____

Primary E-Mail Address: _____ Secondary Email: _____

Parent(s) or Guardian(s) with whom student resides:

Mother/Guardian Name: _____

Father/Guardian Name: _____

Indicate names of other individuals that are authorized to pick your child up from Camp Fairfax:

Name _____ Relationship: _____

Name _____ Relationship: _____

Phone Numbers:

Mother's home phone #: _____

Mother's business phone #: _____

Mother's cell/pager #: _____

Father's home phone #: _____

Father's business phone #: _____

Father's cell/pager #: _____

In case of an emergency or illness— Parent or guardian will be phoned first. List two local people and their phone numbers who maybe available in an emergency:

Local relative/friend _____ Home Phone _____ Cell _____

Local relative/friend _____ Home Phone _____ Cell _____

MEDICAL INFORMATION

Allergy to food (type) : _____

Does the allergy necessitate medical treatment? Yes No

Allergy to insect bite (type) _____

Does the allergy necessitate medical treatment? Yes No

Allergy to medication (type) _____

Asthma medication (type) _____

Asthma (indicate severity) mild moderate severe

Asthma triggered by exercise allergens cold virus

Please provide additional information for any of the conditions checked. (If necessary, further explain any checked items on a separate sheet of paper): _____

Please describe any medical condition which might require care while your child is at school or which might restrict his/her physical activity, such as in contact sports: _____

Parent Signature: _____ Date: _____

Print Name: _____

Please Sign and Return to Camp Fairfax Staff Immediately