

**TOWN OF CORNWALL SUMMER PLAYGROUND CAMP PROGRAM
MEDICAL HISTORY 2022**

CHILD'S NAME: _____ DATE OF BIRTH: _____ AGE: _____
FIRST MI LAST

ADDRESS: _____ GRADE: _____
STREET TOWN ZIP

PARENT/GUARDIAN NAME: _____ #:

PERSON TO CONTACT IN AN EMERGENCY: _____

(IF YOU CANNOT BE REACHED) RELATION TO CHILD
DAYTIME TELEPHONE # _____

ALLERGIES:

MY CHILD HAS THE FOLLOWING ALLERGIES: _____

MY CHILD IS CURRENTLY ON THE FOLLOWING MEDICATION(S) FOR ALLERGIES: _____

MEDICAL CONDITIONS:

MY CHILD HAS THE FOLLOWING CONDITION(S) THAT REQUIRES DAILY **OR** PERIODIC MEDICATION:

REQUIRED MEDICATION(S): _____

ANY SURGERY/PROCEDURE/CHRONIC CONDITION STILL REQUIRING MEDICAL SUPERVISION:

TYPE OF SURGERY: _____

DAILY PROTOCOL AS A RESULT OF SURGERY/PROCEDURE/CHRONIC CONDITION(S):

IF YOU ARE ADVISING THE CAMP DIRECTOR AND MEDICAL STAFF OF ANY PERTINENT MEDICAL INFORMATION, YOUR CHILD'S DOCTOR'S NAME AND PHONE NUMBER *MUST BE PROVIDED.*

DOCTOR'S NAME: _____

ADDRESS: _____ PHONE NUMBER: _____

I WILL BE EXPECTING A FOLLOW-UP PHONE CALL FROM THE CAMP NURSE TO DISCUSS ANY INFORMATION PROVIDED ON THIS FORM.

DATE

SIGNATURE OF PARENT/GUARDIAN