# CHILDREN'S HEALTH PARTNERS

## Parent Input for Camp Forms

**Please provide the following information so the physician can accurately complete your child's camp form.**

Today's Date_____

Child's Name (Last, First)_____DOB:_____

Name of Camp: _____

Type of Camp: (i.e. High Adventure, Scuba, Art, Scout, Soccer):_____

Date/Dates Child Attending Camp_____

Sleepover Camp (Yes or No) _____

Allergies (food, environmental or drug):_____
_____

## Medications List with dosage and time of day taken:

| MEDICATION | DOSAGE | TIME | DAILY OR AS NEEDED | TO BE TAKEN AT CAMP? YES OR NO |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Dietary restrictions: _____
_____
_____

Any limitations in activities at camp:
_____
_____
_____

Any other health information for staff at camp: _____
_____
_____

Revised 4/2019