

Fairfield Parks and Recreation
Health Information Form

Camper Name: _____

Birthdate: _____ Age: _____ Sex: _____

Address: _____ City: _____ State: _____

Name of Parent/Guardian: _____

Phone(H): _____ Phone(W): _____ Cell: _____

Alternate Emergency Contact: _____

Alternate Phone: _____ Alternate Cell: _____

Family Physician: _____ Phone: _____

Family Dentist/Orthodontist: _____ Phone: _____

Medical Insurance Carrier: _____ Policy Group #: _____

Medical Information past or present (please circle):

Asthma	Yes	No	Allergies	Yes	No	Diabetes	Yes	No
Seizures	Yes	No	Hemophilia	Yes	No	Ulcers	Yes	No
ADD/ADHD	Yes	No				High Blood Pressure	Yes	No
Psychiatric Treatment		Yes	No	Other Diseases / Conditions			Yes	No

Please explain each yes circled: _____

Authorized to pick up:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

If staff member is unfamiliar with person signing out the camper, proper ID will be required.

Signature of Parent/Guardian:

_____ **Date:** _____