

## Medical Information

Physician's Name: \_\_\_\_\_

Address & Phone Number: \_\_\_\_\_

Allergies (List all that apply): \_\_\_\_\_

Medicine During Camp: List all medications your child may need to take during camp. Be specific; diagnosis, dosage, medicine prescribed, time of administration: \_\_\_\_\_

Insurance Carrier Name & Phone Number: \_\_\_\_\_

This health history is correct to the best of my knowledge, and the person herein described has permission to engage in all prescribed camp activities except as noted by me. I hereby give permission to the physicians selected by the Recreation Department of Montgomery to order x-rays, routine tests, and treatment for the health of my child, and in the event I cannot be reached in any emergency, I hereby give permission to the physician selected by the Recreation Department to hospitalize, secure prior to treatment for, and to order injection and/or anesthesia and/or surgery for my child as named above.

Signature of Parent or Guardian: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_