CHILDREN'S HEALTH PARTNERS

Parent Input Form

Pre-Camp Form Completion by MD

Today's Date_____

Date/ Dates Child Attending Camp_____

Sleepover Camp (Yes or No) _____

Child's Name (Last, First) _____

Child's Date of Birth_____

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: _____
_____
_____
_____
_____

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