

**MEDICAL FORM**  
**St. Thomas Reformed Church**  
**Summer Camp**

Name of Child \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Names of Parents/Guardian \_\_\_\_\_ Phone \_\_\_\_\_

Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_

Significant Family History \_\_\_\_\_

**MEDICAL HISTORY**

Significant past illnesses, injuries, operations, physical limitations, disabilities

Allergies

Special Medications

Special Diets

Contagious Diseases (check all that apply)

- |   |   |
|---|---|
| <input type="checkbox"/> Measles        | <input type="checkbox"/> Chicken Pox    |
| <input type="checkbox"/> Mumps          | <input type="checkbox"/> German Measles |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Scarlet Fever  |

Other (please specify) \_\_\_\_\_

**Immunization & Tests: A copy of immunization card/record must be submitted  
with the medical form prior to the first day of camp.**

**CONSENT FOR EMERGENCY CARE**

I hereby give permission for a certified camp staff member to administer First Aid/CPR, call for transport and/or provide transport to the hospital for my child in the event of a medical emergency.  **YES**  **NO**

\_\_\_\_\_  
**PRINT** Parent/Guardian Name

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date