FCA Summer Day Camp Health Screening Form

Child's Name: _____

Parent Names: _____ Phone 1: _____ Phone 2:_____

Emergency Contact: _____ Phone: _____

Physician's Name: _____ Phone: _____

Does your child have any medical conditions that would……

Limit participation in activities? _____ Yes _____ No

If YES, Please Describe: _____

_____

_____

Require administering medicine? _____ Yes _____ No

If YES, Please Describe & Complete Consent to Administer Medicines: _____

_____

_____

I hereby authorize FCA Camp to seek medical treatment for my child in the event of an emergency, including transportation by ambulance to the nearest hospital.

Parent Initials _____

I have fully disclosed all known medical information that would limit my child's participation in camp and give my child permission to participate with above mention restrictions, if any.

_____ _____

Parent Signature Date