

**LAST NAME:** \_\_\_\_\_ **First Name:** \_\_\_\_\_  
**CELL PHONE:** \_\_\_\_\_  
**PARENT'S PHONE NUMBER:** \_\_\_\_\_

<b>SONSHINE CAMP HEALTH INFORMATION</b>
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**Child's Name** \_\_\_\_\_ **Age** \_\_\_\_\_

**Allergies/Medical Information: (Please specify and provide instructions)** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Any restrictions of activity?** \_\_\_\_\_

**Any Medication may need to be administered ?** If yes, please provide instructions: \_\_\_\_\_  
\_\_\_\_\_

**IN CASE OF EMERGENCY NOTIFY:**

Name: \_\_\_\_\_ Relationship \_\_\_\_\_  
Phone: \_\_\_\_\_

Name of Child's Physician: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Medical Insurance Co. \_\_\_\_\_  
Medical Insurance Number \_\_\_\_\_

The health history is correct so far as I know; and the person herein described has permission to engage in all prescribed activities except noted by me above.

In the event that I cannot be reached in an emergency, I authorize the Church Camp to obtain whatever medical assistance may become reasonably necessary for my child.

I further authorize the Physician or Surgeon to whom my child is taken to perform all medical services or to have such medical services performed which in the opinion of the Physician or Surgeon are reasonably necessary to the care of my child.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_