



# St. John's

## EPISCOPAL SCHOOL

### Summer Camp Medical Form

Name: \_\_\_\_\_

Does participant attend a school in the State of Maryland? Yes \_\_\_ No \_\_\_

If no, a copy of your child's immunization record must be on file before start of program

Date of last Tetanus shot: \_\_\_\_\_ (DTP or DT, do NOT leave blank)

Health Insurance: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Physician: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Dentist: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Medical Condition: \_\_\_\_\_

Allergies: \_\_\_\_\_

Medications: \_\_\_\_\_

Glasses/Contacts: \_\_\_\_\_

#### EMERGENCY CONTACTS

(persons to call if parent/guardian cannot be reached)

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_

Cell: \_\_\_\_\_

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_

Cell: \_\_\_\_\_