



DELAWARE ART MUSEUM

Session _____

Participant's Name _____

Date of Birth _____

MEDICAL INFORMATION:

Please complete the following immunization information for our records:

Month/Year	Immunization	Month/Year	Immunization
_____	DTP (Diphtheria, Tetanus, Pertussis)	_____	HIB (Hemophilus Influenza)
_____	OPV (Polio/Oral)/ IPV (Polio Injected)	_____	MMR (Measles, Mumps, Rubella)

List any known conditions, diseases, etc, which may limit or restrict the above person from participating in camp activities _____

Camp staff is **NOT** permitted to dispense medication.

Due to food allergies, camp staff is **NOT** permitted to provide food or beverages (other than water) to camp participants. Parents/guardians must provide lunches and snacks for children.

I hereby certify that my son/daughter is fully capable of participating in this camp program.

Parent or guardian signature

Date

EMERGENCY INFORMATION:

In case of emergency please contact:

Name

Relationship

Phone number(s)

Or, if unable to reach the above person, please contact:

Name

Relationship

Phone number(s)

LIST PEOPLE AUTHORIZED TO PICK UP YOUR CHILD _____

In the event of an emergency, if I cannot be contacted, you have my permission to treat my child.

Parent or guardian signature

Date

Insurance Company

Policy Number

THIS FORM MUST BE RETURNED PRIOR TO THE FIRST DAY OF CAMP