

# Myrick Conservation Center Summer Camp Program

## Medical Form 2009



**BRANDYWINE  
VALLEY  
ASSOCIATION**

1760 Unionville-Wawaset Road  
West Chester, PA 19382  
610-793-1090



**Red Clay  
Valley  
Association**

Please complete this form and return it to us **two weeks** before the start of your child's first camp session.  
**Participants will not be checked in on Mondays without this completed form.**

Child's Name:  Male  Female    Age:    Grade in September:

All Camps Child is Attending:

Camp 1 Name	
Camp 1 Week	
Camp 2 Name	
Camp 2 Week	

Camp 3 Name	
Camp 3 Week	
Camp 4 Name	
Camp 4 Week	

Guardian's Name: \_\_\_\_\_ Home Phone (    )    -    Work Phone (    )    -    x  
Cell Phone (    )    -

Guardian's Name: \_\_\_\_\_ Home Phone (    )    -    Work Phone (    )    -    x  
Cell Phone (    )    -

Home Address: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Who will be picking up your child each day? Please list all possible persons.** No child will be released to anyone not on this list without written permission from his/her parent or guardian. Please include parent and guardian names on this list.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

Child's swimming ability (check one):  Non-swimmer  Weak  Fair  Good  Excellent

**Emergency Contacts (other than guardians):**

1. Name: \_\_\_\_\_ Relationship to Camper: \_\_\_\_\_  
Home Phone (    )    -    Work Phone (    )    -    Cell Phone (    )    -

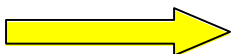
2. Name: \_\_\_\_\_ Relationship to Camper: \_\_\_\_\_  
Home Phone (    )    -    Work Phone (    )    -    Cell Phone (    )    -

Name of Family Doctor: \_\_\_\_\_ Office Phone (    )    -    Year of last Tetanus shot \_\_\_\_\_

Name of Family Dentist: \_\_\_\_\_ Office Phone (    )    -

Name of Insurance Carrier: \_\_\_\_\_ Policy Number \_\_\_\_\_

**Consent Given:** If my child needs emergency medical care and no one can be contacted at the above phone numbers, I give my consent for the transportation of my child by ambulance or BVA/RCVA staff member and for the administration of any treatment deemed necessary by licensed medical personnel.



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

\_\_\_\_\_  
Date

Please indicate any allergies or medical conditions. \*Provide details about medication in the box below.

Has your child ever experienced food allergies? No Yes If yes, to what?

Medication taken?

Has your child ever been stung by a bee? No Yes If yes, did s/he have an allergic reaction? No Yes  
If yes, will s/he be carrying an Epi-pen during camp? No Yes If not, why?

Has your child ever been exposed to poison ivy? No Yes Don't Know  
If yes, did s/he have an allergic reaction? None Slight Severe Medication taken?

Asthma: No Yes Medication taken?

Inhaler? No Yes

Diabetes: No Yes Medication taken?

Other:

Medication taken?

Comments:

Please check off any physical limitations that apply to your child. Describe details under "comments."

Glasses/Contacts Orthodontics Hearing/Speech Impairment

Other limitations:

Comments:

**\*If your child takes any medication, please read the important information in this box:**

Myrick Conservation Center staff will not administer medications of any kind. Your child may bring medication with him/her to the program in his/her lunchbox or backpack. At your written request (below) Myrick Conservation Center staff will remind your child when the medication is due. However, the care and administration of the medication remains the sole responsibility of you and your child. Please indicate below the medication(s) that your child will bring to the program and the time(s) that you wish your child to be reminded to take the medication. We will not be able to honor your request without your signature below.

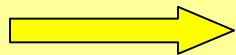
My child will bring the following medication(s) to the Myrick Center summer program and I request that s/he be reminded about the medication(s) at the time(s) listed next to the medication.

Medication: Taken for: Dosage: Time(s) of day:

Possible side effects of medication:

Medication: Taken for: Dosage: Time(s) of day:

Possible side effects of medication:

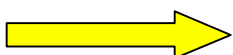


Signature of Parent/Guardian

Date

**Consent for Participation:**

I am the parent or guardian of \_\_\_\_\_ and I consent to his/her participation in the Myrick Conservation Center summer program administered by the Brandywine and Red Clay Valley Associations, including, if applicable, all off-site field trips (and associated transportation) that are outlined in the program description. I understand the types of activities that the program involves including physical activities that may involve risk of physical injury. I understand that the Brandywine and Red Clay Valley Associations cannot safeguard against all such injuries and expressly agree to assume risk of and, to the fullest extent permitted by law, waive and release the Brandywine and Red Clay Valley Associations and its officers, directors, agents and employees from any claim of liability for personal injury and any other loss, damages or injury incurred by my child during the program.



Signature of Parent/Guardian

Date