



Full name of child _____

Date of birth _____

CREATIVE ARTS AT PARK

171 Goddard Avenue
Brookline, Massachusetts 02445
(617) 274-6065

EMERGENCY MEDICAL INFORMATION

PARENT/GUARDIAN FULL NAMES

1. _____ Day phone: _____ Home _____ Cell phone _____

2. _____ Day phone: _____ Home _____ Cell phone _____

Child's doctor _____ Daytime phone _____

Child's dentist _____ Daytime phone _____

Person(s) to be notified in an emergency if neither parent can be reached:

Name & relationship _____ Daytime phone _____

Name & relationship _____ Daytime phone _____

If current or recent medical problem is likely to make a first aid situation particularly stressful for your child, please note the details here:

<u>Please specify if there are any:</u>
Dietary restrictions _____
Medications _____
Allergies _____
Does your child have physical, emotional or learning needs?
Yes _____ No _____
If yes, please attach explanation.

MEDICAL INSURANCE INFORMATION

Please fill in as applicable:

Children's Medical Center no. _____ Family Insurance Company name & no. _____

EMERGENCY MEDICAL RELEASE

In case of medical emergency at any time during my child's enrollment at Creative Arts at Park, I understand every effort will be made to inform me (parent/guardian). In the event I cannot be reached, I hereby give permission to the physician selected by the Camp to hospitalize, secure proper treatment for, and order injection, anesthesia or surgery for my child, as named on this medical form. I further agree to release and hold harmless Creative Arts at Park and physician selected by the Camp from any liability arising out of such emergency treatment.

Parent/Guardian signature _____

NOTE: PLEASE INFORM THE CAMP IMMEDIATELY IF THERE IS ANY CHANGE IN THESE LISTINGS DURING THE SUMMER. (SEE REVERSE SIDE)

NON-PRESCRIPTION RELEASE FORM

I hereby give permission to the Camp nurse and/or other appropriate person to administer to _____ the following
(child's name)
non-prescription medications (Tylenol, Motrin, Robitussin) in the event of headache, low-grade fever, complaints of minor aches, pains or cold symptoms.

Parent/Guardian signature _____

Date _____

Please list any medication therapy (in or out of Camp) your child is currently taking:

Medication: _____

Dose: _____

Frequency: _____

Name of licensed prescriber: _____

PHYSICIAN SIGNED REPORT (*including physical exam report & immunization records*) is attached: Yes ____ No ____ . If NO, it will be sent or faxed on (date) _____.

DEADLINE: May 1 - NOTE: Health exam must be dated within 2 years of camp start date.

Please sign here to indicate that you have read BOTH sides of the Emergency Medical Form
