CAMP GSC

Emergency Contact and Medical Information Form

Student's Name: _____

Parent's Name: _____

Home Phone: _____

Parent's Work/Cell Phone(s): _____

Student's D/O/B: _____

Emergency Contact if parent/guardian cannot be reached:

Name: _____

Phone No.: _____

Relationship to Student: _____

Please list any allergies that the student has:

_____

_____

Should the student be restricted from any type of activity?

_____ Yes _____ No If yes, _____

Will the student be taking any medication during the day? _____ Yes _____ No

If yes, _____

If yes, does any medication need to be monitored, kept separately by an adult, and/or refrigerated?
_____ Yes _____ No (If so, medications must be in their original labelled container.)

If yes, please specify: _____

If you are supplying an EpiPen, will it be left with GSC all week or brought in daily? _____

Is there anything medically or otherwise that we should know about the student?

_____

_____

Medical Insurance Company Name: _____

Address: _____

_____

Policy Number: _____

Phone Number: _____

Physician's Name: _____

Phone Number: _____

I, the parent or legal guardian of _____ (my child) authorize Good Shepherd Catholic School/Camp GSC personnel to obtain medical care for my child in the event such care is necessary. I understand that I will be contacted in the event my child requires medical attention. I grant a licensed physician or accredited hospital permission to perform any medical and/or surgical procedures that are essential in an emergency for the treatment of my child and agree to be responsible for payment of such care. I release Good Shepherd Catholic School, its employees, and agents from any damages, liability, or loss resulting from their securing in good faith medical care for my child. I further acknowledge and understand that I will be responsible for any medical bills that may be incurred on behalf of my son/daughter for physical illness or injury that he/she may sustain during the program.

Parent/Guardian Signature: _____ Date: _____