

# Camp Flips Medical/Emergency Information

## Participants

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

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

Address: \_\_\_\_\_

## Emergency Phone Numbers

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

home work cell \_\_\_\_\_

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

home work cell \_\_\_\_\_

### Emergency Contact:

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

## Medical Information

Any allergies to  
food/insects/plants? \_\_\_\_\_

Please list \_\_\_\_\_

\_\_\_\_\_

Epi Pen/ Inhaler (camper provide) \_\_\_\_\_

Any activity restrictions?

Please explain \_\_\_\_\_

Any medication

To be given? \_\_\_\_\_

Please list times to be given: \_\_\_\_\_

Parent's Signature \_\_\_\_\_ Date \_\_\_\_\_