

# WEEKEND FAMILY CAMPING PROGRAMS - OCKANICKON

Please complete the following information for everyone in your family who is staying at camp

FAMILY NAME: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

CUB PACK: \_\_\_\_\_ PHONE: (\_\_\_\_) \_\_\_\_\_

This health and safety record is correct so far as I know for all of the individuals listed. The persons herein described have permission to engage in all prescribed activities, except as noted by me. In the event that I can not be reached in an emergency, I hereby give permission to the physician, selected by the adult leader in charge, to hospitalize, secure proper anaesthesia, or order injection or surgery for any of the persons listed herein.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**NAME:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **AGE:** \_\_\_\_\_ **SEX:** \_\_\_\_\_

In the event of an emergency contact: \_\_\_\_\_ PHONE: (\_\_\_\_) \_\_\_\_\_

Name of personal physician: \_\_\_\_\_ PHONE: (\_\_\_\_) \_\_\_\_\_

Personal health/accident insurance carrier: \_\_\_\_\_ Policy No.: \_\_\_\_\_

Any condition requiring medication? \_\_\_\_\_ If YES, please explain: \_\_\_\_\_

Any medical restrictions? \_\_\_\_\_ If YES, please explain: \_\_\_\_\_

EXPLANATIONS OF ANY CIRCLED ITEMS \_\_\_\_\_

Please circle any that apply and explain below:

- |             |                     |
|-------------|---------------------|
| Asthma      | Diabetes            |
| Convulsions | Heart Trouble       |
| Allergies   | Fainting Spells     |
| Cancer      | High Blood Pressure |
| Hemophillia | Leukemia            |

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