
Health & Emergency Information

Knightdale Summer Day Camp Circle One: Adventure 5-7 Explorer 8-10 Quest 11-13

Please Complete and return to the Parks & Recreation Department prior to your child attending camp

Child's Name: _____

Name of Parent/Guardian: _____

Home Phone: _____ Work: _____ Cell/Pager: _____

Name of Physician: _____ Phone: _____

Name of Insurance Company: _____ Policy Number: _____

Please indicate (check if YES) if your child has or is subject to:

- | | | |
|--|--|---|
| <input type="checkbox"/> asthma | <input type="checkbox"/> diabetes | <input type="checkbox"/> fainting spells |
| <input type="checkbox"/> heart trouble | <input type="checkbox"/> seizures | <input type="checkbox"/> sinus trouble |
| <input type="checkbox"/> ear infections | <input type="checkbox"/> motion sickness | <input type="checkbox"/> plant allergies |
| <input type="checkbox"/> bee sting allergy | <input type="checkbox"/> hyperactivity | <input type="checkbox"/> peanut allergies |
| <input type="checkbox"/> other _____ | | |

Please provide background information on any box checked above: _____

Does your child currently have a condition requiring medication? Please explain: _____

Any restrictions of activity for medical reasons? Please list: _____

Please provide any other information you feel would help our staff better serve your child's needs: _____

Swimming ability (include lessons taken): _____
