

# CAMP AUXILIUM TODDLER PROGRAM INFORMATION UPDATE

Please return to Camp Auxilium ASAP

Child's Name \_\_\_\_\_ D.O.B. \_\_\_\_\_ Room \_\_\_\_\_

First Contact Person \_\_\_\_\_ Phone # \_\_\_\_\_

E-mail \_\_\_\_\_ Home # \_\_\_\_\_

Mother's Name \_\_\_\_\_ Father's Name \_\_\_\_\_

Mother's work # \_\_\_\_\_ Father's work # \_\_\_\_\_

Mother's Cell # \_\_\_\_\_ Father's Cell # \_\_\_\_\_

Pediatrician/Family Dr. & Phone # \_\_\_\_\_

Hospital Preference \_\_\_\_\_

Present Medical Problems & Chronic Conditions: \_\_\_\_\_

Allergies: \_\_\_\_\_

Medications taken regularly: \_\_\_\_\_

If Parent (s) **CANNOT** be reached in an emergency(child must be picked up within an hour), CA should call:

Name \_\_\_\_\_ Phone # \_\_\_\_\_

Cell # \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Name \_\_\_\_\_ Phone # \_\_\_\_\_

Cell # \_\_\_\_\_

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**Emergency Treatment Permission:** In the event of an emergency, it is required for us to have your consent for your child to receive any medical treatment. Your signature below indicates that you have given us permission to have your child treated IF we are unable to contact you.

**Date:** \_\_\_\_\_ **Signature of Parent/Guardian** \_\_\_\_\_

