

MEDICAL FORM



&

ALLERGY INFORMATION

Child's Name: _____ Date of Birth: _____

Pediatrician's Name: _____ Phone #: _____

Describe any special medical/health conditions and current treatments:

Prescribed Medications:

Dosage: _____ Duration/Time Given: _____

Possible Side Effects: _____

Describe any ALLERGIES & REACTIONS (please clearly indicate if allergy/reaction is *life threatening*):

Allergy Medications: _____

Dosage: _____ Duration/Time Given: _____

Epi-Pen: YES _____ NO _____

What accommodations can we make at W.I.L.D.K.A.T.S. Camp to help with allergy prevention and/or any health conditions?

* PLEASE inform Alvesa Thomas of any changes to medications or updated health information.