Child Information Form

2024 Summer Camp

Child's Last Name	Child's First name	MI	Sex	DOB

Living Arrangement: ☐ lives with both parents ☐ lives with mother ☐ lives with father ☐ lives with Guardian	T-Shirt Size:	Home Phone

Address	Cell Phone Number

City	State	Zip	Family Email Address (For E-Mail Alerts):

Parent/Guardian Information

Please indicate the order in which to make contact in case of emergency, illness or other unforeseen circumstance by circling 1,2,3 or 4 for the name as well as phone numbers to be called. When choosing the order, please keep in mind each person's accessibility, as well as that calls may occur between 7:00 am and 6:00 pm.

Name	Home Phone 1 2 3	Cell Phone 1 2 3	Place of Employment	Work Phone 1 2 3
Name	Home Phone 1 2 3	Cell Phone 1 2 3	Place of Employment	Work Phone 1 2 3

Emergency Contacts

Please list emergency contacts in the order in which they should be contacted in case of an emergency. Also indicate in which order to use the phone numbers listed for each emergency contact by circling 1,2, or 3.

Name: Address:	Home Phone 1 2 3	Cell Phone 1 2 3	Work Phone 1 2 3	Relationship to Child
Name: Address:	Home Phone 1 2 3	Cell Phone 1 2 3	Work Phone 1 2 3	Relationship to Child

Additional Authorized Pick-Ups

The people listed below will be the ONLY people, other than parents/guardians allowed to pick-up the child noted above. Photograph Identification is required upon pick-up.

Name	Address	Relationship to Child	Phone
1.			
2.			

Health Information

Child's Physician	Medical Facility Name	Medical Facility Phone Number

Medical Facility Address	Hospital Preference: ☐ Aurora, ☐ Bellin, ☐ St. Mary's, ☐ St. Vincent

Sunscreen & Insect Repellent Authorization (Insect repellent & sunscreen must be brought from home.)

I authorize my child to self-apply sunscreen ☐Yes ☐No Brand Name:_____ SPF Strength:_____

I authorize my child to self-apply repellent ☐Yes ☐No Brand Name:_____ Ingredient Strength:_____

Medical Device Consent

- Any and all medical treatments, devices, or medications must be provided by parent/guardian.
- If such devices, medication, or treatments are present at camp, staff must be notified via medication authorization form.

I give _____ permission to carry his/her own medical device_____,
(Name of Child) (List device(s) they will carry)
with their belongings while at camp. I also give permission for my child to administer this device when necessary with supervision by staff.

Health History (indication of any health history conditions **MAY** require further State required paperwork)

Does your child have a history of: ☐ ADD/ADHD/Behavioral Disorders ☐ Asperger's Syndrome ☐ Asthma ☐ Autism
☐ Cognitive Disability ☐ Cerebral Palsy/Motor Disorder ☐ Diabetes ☐ Learning Disability
☐ Gastrointestinal or Feeding Concerns ☐ Heart Problems ☐ Epilepsy/Seizures
☐ Physical Handicap ☐ Sensitivity to Sun ☐ Food/Milk Allergies ☐ Non-Food Allergies
☐ Other(describe)_____

OVER →

Health History (Continued)

1.	Please describe any health concerns checked above:
2.	Triggers that may cause problems (specify):
3.	Signs or symptoms to watch for (specify):
4.	Action steps for camp staff to take (specify):
5.	When to call parents regarding symptoms or failure to respond to treatment:
6.	When to consider emergency care:
7.	Any additional information that may be helpful to staff:

- Please contact Camp Director if your child has any special medical needs or conditions that camp should be aware of.
- Indication of any health history conditions **MAY** require further State required paperwork.

Immunization History

The following are the minimum required immunizations. Children entering kindergarten must have received one dose of DTP/DtaP/DT after the 4th birthday to be compliant. Measels, mumps, and rubella vaccines must have been received on or after the 1st birthday.

List the month, day, and year your child received each of the following immunizations (or attach a separate sheet with immunization records). DO NOT USE AN 'X' OR CHECKMARK to indicate it has been completed. Contact your doctor or public health agency to obtain dates if necessary.
*A copy can be faxed or mailed from your Doctor.

TYPE OF VACCINE	FIRST DOSE mm/dd/yy	SECOND DOSE mm/dd/yy	THIRD DOSE mm/dd/yy	FOURTH DOSE mm/dd/yy	FIFTH DOSE mm/dd/yy
DTP/DTaP/Td Diphtheria Tetanus-Pertussis (Whooping Cough)					
Polio					
Haemophilus influenza (HIB)					
Hepatitis B					
Measels, Mumps, Rubella (MMR)					
Varicella (Chicken Pox)					

REQUIREMENTS:

2 yrs. – Kindergarten:
-4 DTP/DtaP/DT
- 3 Polio
- 1 MMR
- 3 Hep B
- 3 HIB
- 1 Varicella

At Kindergarten entrance:
- 4 DTP/DtaP/DT
- 4 polio
- 2 MMR
- 3 Hep B
- 1 Varicella

☐ This child is not immunized for religious reasons.

☐ This child is not immunized for personal conviction reasons.

Parental Consent:

- By signing below you are authorizing that all information provided on this form is accurate to the best of your knowledge.
- You have read through and agree to all camp policies and procedures outlined in the Allouez Summer Day Camp handbook.
- You give consent for emergency care or medical treatment to be provided to your child.

Parent/Guardian Signature:_____ Date:_____