City of Loveland

Youth Day Trip
Emergency Contact Form

Today's Date
MM/DD/YY
/ /

Camper Name: _____ **Birthdate:** _____

Nickname(s): _____ **Age:** _____ **Grade:** _____ **Gender:** M F

Parent/Guardian Name(s): _____

Address: _____ **City/State/Zip:** _____

Home Phone: _____ **Other Phone (C/W):** _____

MOTHER/GUARDIAN INFORMATION:

Name _____
Address _____
City/State/Zip _____
Home Phone _____
Cell Phone _____
Employer _____
Work Phone _____
Email Address _____
Authorized to Pick Up Child: Y N
Special Instructions for contacting this parent:
_____
_____
_____

FATHER/GUARDIAN INFORMATION:

Name _____
Address _____
City/State/Zip _____
Home Phone _____
Cell Phone _____
Employer _____
Work Phone _____
Email Address _____
Authorized to Pick Up Child: Y N
Special Instructions for contacting this parent:
_____
_____
_____

Please list two additional emergency contacts other than the parents/guardians listed above in the event that neither are able to be reached:

Name _____ **Relationship** _____
Address _____ **Phone** _____
Authorized to pickup child? YES NO

Name _____ **Relationship** _____
Address _____ **Phone** _____
Authorized to pickup child? YES NO

Please list any other person(s) to whom child may be released:

Name _____ **Relationship** _____
Address _____ **Phone** _____

Name _____ **Relationship** _____
Address _____ **Phone** _____

City of Loveland

Medical History & Information Form

Please check all illnesses that your child HAS had

☐ Chicken Pox ☐ Measles ☐ Rubella ☐ Hay Fever ☐ Rheumatic Fever ☐ Asthma
☐ Poliomyelitis ☐ Mumps ☐ Epilepsy ☐ Diabetes ☐ Whooping Cough ☐ Strep Throat
☐ Other _____

Please fill out information below

Surgery/Accidents/Illnesses/Chronic Health Problems: _____

_____

Describe any physical or medical condition requiring special attention by staff: _____

_____

Does your child have any emotional problems and/or behaviors we should know about? _____.

_____

Check those allergies staff should be aware of and give the prescribed routine below:
☐ Food (type)_____ ☐ Insect Bites/Stings_____
☐ Medications_____ ☐ Other_____

Date of most recent medical examination of this child ____/____/____.

Has participant had a tetanus shot? ☐ Yes ☐ No If yes, when? ____/____/____

Medications that need to be administered during the camp/trip day will need a physician's signature. Please call (970) 962-2487 or email kelly.rathbun@cityofloveland.org to obtain the required forms.

Side effects/impact medication (s) may have on participant's health/behavior:_____

Physician/Health Care Professional:_____ Phone: (____)_____
Address: _____
Dentist Name:_____ Phone: (____)_____
Address:_____
Hospital of Choice:_____ Phone: (____)_____
Address:_____
Does your child have any intolerances to drugs, medication, sunscreen, or food? _____

_____

Is there any other information we should know? _____

_____

In case of serious illness or injury, may we . . . . .

Contact participant's Doctor? ☐ Yes ☐ No
Call an ambulance? ☐ Yes ☐ No
Administer basic First Aid? ☐ Yes ☐ No

I, _____, testify that this medical history and all information is correct as far as I know and that my child, _____, has permission to engage in all prescribed activities, unless otherwise stated.

Parent/Guardian Signature: _____ **Date:** _____