



Yarmouth Community Services Program Participant

Camper Emergency Medical Information

Today's Date: _____

Child Name(s): _____

Address: _____

Telephone #: _____ Email: _____

Mother's Name: _____ Work Phone: _____

Father's Name: _____ Work Phone: _____

Person to contact in case of an emergency

1. Name: _____ Primary Phone #: _____

Relationship: _____ Cell Phone #: _____

2. Name: _____ Primary Phone #: _____

Relationship: _____ Cell Phone #: _____

Special medical information (conditions, allergies, medications, etc.) _____

Physician: _____ Phone #: _____

Address: _____

Preferred Hospital: _____

Medical Insurance

Carrier: _____

Policy #: _____