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 #:_____