

**CHILDREN'S ARTS INSTITUTE
MEDICAL INFORMATION FORM**

MEDICAL BACKGROUND	CHILD #1	CHILD #2	CHILD #3
Your child's first name and last name			
CURRENT HEALTH CONDITIONS			
Epilepsy/Convulsions	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Defect / Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding / Clotting Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
IMMUNIZATIONS			
Chicken Pox	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Measles	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
German Measles	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mumps	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
ALLERGIES			
Insect Stings	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Penicillin	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other Drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Food	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please comment on "Yes" answers to Current Health Conditions or Allergies			
Medications to be administered at camp			

EMERGENCY AUTHORIZATION

I, the undersigned parent / guardian of said minor, do hereby certify that my child(ren) is (are) physically and mentally able to participate in camp activities. In the event of illness or accident I hereby grant full authority to the Children's Arts Institute to take whatever actions it may consider to be warranted under the circumstances regarding the health and safety of my child(ren). Such authority shall include the power to consent to any X-ray examination, anesthesia, medical or surgical diagnosis or treatment, and hospital care under the supervision of a licensed medical practitioner, or to consent to an X-ray examination, anesthetic, dental or surgical diagnosis or treatment, and hospital care to be rendered by a licensed dental practitioner. Any such diagnostic treatment or care shall be rendered at my expense. In the event of injury or illness I understand that due effort to contact me to assist in any decision will be made by the Children's Arts Institute, but that said Institute will be compelled to use its best judgment should it not be possible to contact me. I hereby indemnify the Children's Arts Institute and any director, teacher or counselor from any liability because of the exercise of such consent.

Signature of Parent or Guardian

Please Print Parent's or Guardians Full Name

Date