Body Zone Sports and Wellness Complex
Summer Adventure Camp 2025 - MEDICAL FORM

Camper Name _____

Physician Name and Phone Number _____

Will your child be taking medication (circle one): YES NO'

If yes, please list medications here:

_____

_____

_____

_____

Please send all medications in a clear resealable bag with label and specific instructions.

Does your child have any allergies (circle one): YES NO

TYPE:	EXPLAIN SYMPTOMS AND SEVERITY:
☐ Bee sting	_____
☐ Peanut/Nut	_____
☐ Drugs	_____
☐ Food	_____
☐ Other	_____

Does your child have chronic or recurring illness (circle one): YES NO

TYPE	PLEASE EXPLAIN IN DETAIL:
☐ Asthma	_____
☐ Diabetes	_____
☐ Seizures	_____
☐ Cardiac	_____
☐ Other	_____

Are there any limitations/issues (including non-swimmers) we should be aware of (circle one): YES NO

If yes, please explain: _____

_____

PICK UP CONSENT

I give permission for the following persons to pick up my child(ren) from camp. (PHOTO I.D. REQUIRED)

_____ _____

NAME **PHONE**

_____ _____

NAME **PHONE**