

# Body Zone Sports and Wellness Complex

## Summer Adventure Camp 2026 – 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:

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**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: \_\_\_\_\_

## PICKUP CONSENT

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

NAME \_\_\_\_\_

PHONE \_\_\_\_\_

NAME \_\_\_\_\_

PHONE \_\_\_\_\_