

Visiting Summer Camp – Allergies & Medical Conditions Form

To be completed for each camper or staff member attending the trip.

Participant Information

Camp Name: _____

Trip Date(s): _____

Participant's Full Name: _____

Date of Birth: _____

Emergency Contact Name: _____

Relationship: _____

Phone Number(s): _____

Allergies

Please list all known allergies, including food, environmental (e.g., bees, pollen), or medication allergies:

Allergen	Reaction	Medication Required	Carries EpiPen?

Additional notes or instructions:

Medical Conditions

Please list any medical conditions, such as asthma, diabetes, seizures, heart conditions, etc.:

Condition	Symptoms	Medications/Actions to Take

Additional information or care instructions:

Medications

Will the participant need to take any medication during the trip? ☐ Yes ☐ No

If yes, please list:

Medication Name	Dosage	Time(s) Given	Self-Administer?

Authorization & Acknowledgment

I confirm that the above information is accurate and complete to the best of my knowledge.
I authorize Camp Hope personnel to assist in the administration of medications and first aid as needed. In case of emergency, I authorize medical care to be provided if I cannot be reached.

Parent/Guardian/Authorized Adult Name: _____

Signature: _____ Date: _____