

**Camp Heritage 2019  
Health Information and  
Permanent Field Trip Permission Form**

Child's Name \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_\_

Address, City, Zip \_\_\_\_\_ Home Phone \_\_\_\_\_

Father's Work Phone \_\_\_\_\_ Cell \_\_\_\_\_

Mother's Work Phone \_\_\_\_\_ Cell \_\_\_\_\_

Doctor's Name \_\_\_\_\_ Phone \_\_\_\_\_

Emergency name and phone of person if you cannot be reached \_\_\_\_\_

Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Medical Insurance Co. \_\_\_\_\_ Policy ID # \_\_\_\_\_

Name of Insured \_\_\_\_\_ Group # \_\_\_\_\_

Does the camper have any known medical conditions or problems that Camp Heritage administration, counselors, substitutes or chaperones should be made aware of? Yes \_\_\_\_\_ No \_\_\_\_\_

If so, please explain \_\_\_\_\_

Does the camper have any known allergies? Yes \_\_\_\_\_ No \_\_\_\_\_

If so, please explain \_\_\_\_\_

Does the camper take any type of medication on a regular basis? Yes \_\_\_\_\_ No \_\_\_\_\_

If so, please list \_\_\_\_\_

I give permission to Camp Heritage administration, counselors, substitutes, and chaperones to provide or secure immediate medical attention if needed. Yes \_\_\_\_\_ No \_\_\_\_\_

Parent/Guardian \_\_\_\_\_

I give permission for Camp Heritage personnel to administer Benadryl in the case of an allergic reaction that is deemed an emergency by the Camp Heritage administration, counselors, substitutes or chaperones.

Yes \_\_\_\_\_ No \_\_\_\_\_

Parent / Guardian \_\_\_\_\_ Date \_\_\_\_\_

I/We the undersigned parent(s) or legal guardian(s) of the child named above, a minor child, hereby give my/our permission and consent for him/her to accompany the administrators, counselors, substitutes or chaperones on field trips during Camp Heritage 2019 and participate in any activities therein. The administrators, counselors, substitutes or chaperones are hereby authorized to seek medical treatment and to incur medical expenses he/she deems necessary for the above named child. The administrators, counselors, substitutes or chaperones are to phone me, collect if necessary, at the earliest possible time after the student receives any such treatment or is admitted to a medical facility. I understand that my insurance will be primary insurance.

Signed (Parent/Guardian) \_\_\_\_\_ Date \_\_\_\_\_