



PERSONAL INFORMATION FORM (Please fill within this form)

Child's Name _____ Age ____ Sex _____ Pronoun _____

How did you learn about our camp? [] friends [] school [] website [] camp fair [] other
My child has gone camping before [] with family [] without family [] with school [] never
My child's skin (also lips and ears) tends to sunburn [] easily [] normally [] less than normally
My child gets carsick [] often [] occasionally [] never
I expect my child to be [] rather [] slightly [] not at all homesick.
At normal camp activities, I expect my child to be [] over-cautious [] reasonably prudent [] under-cautious
My child [] cannot [] could [] will bring a tent, sleeping _____ (Number) children.
My child is a [] good [] fair [] poor [] non swimmer.
I give permission for my child to swim without a flotation device, under adult supervision. _____

Covid Vaccination: Kind _____. Shot Dates _____, _____. Boosters Dates _____, _____, _____

For any "yes" below, please give details; use a separate sheet if necessary. Make sure your response fits neatly within the field. Has your child had any serious illnesses or injuries in the past two years?

Does your child have any severe or ongoing medical problems or physical disabilities? (Include asthma, allergies, and drug allergies [especially to penicillin].)

Should there be any particular limits on your child's physical activities?

Does your child have any special dietary needs or restrictions -- e.g. vegetarian/vegan, or food allergies? Specify special foods if you would like us to supply them.

Are you sending any medications for your child to take, on a regular or as-needed basis? [] Y [] N If so, please inform us about them and provide written instructions, even if you trust your child to take them properly.

Are there any conditions or problems, physical or emotional, which might cause your child embarrassment or distress among other children, or might require special attention from our staff? (E.g., bedwetting, nightmares, sleepwalking, recent family death or separation, high distractibility, low concentration.) Please think also about tendencies to ignore directions, to have quarrels or difficulties with other children, to sulk, or to wander off. (If diagnosis of ADD or ADHD has been considered, please discuss this explicitly with us.)

Do you want to place any restrictions, for your child, on the camp's protocols of treatment for minor conditions, listed on a separate sheet? [] Y [] N . If "Yes," please specify:

Special conditions (if applicable): for any occurrence of _____ consult _____ immediately.



MEDICAL, SWIMMING, & PICTURES PERMISSIONS FORM

- 1. Authorization to Consent to Treatment of Minor: The undersigned, who is one of the parents having legal custody, or the legal guardian, of _____, a minor, hereby authorizes the adult personnel of Camp Chrysalis, into whose care said minor has been entrusted, to consent to any X-ray examination, anaesthetic, medical or surgical diagnosis or treatment and hospital care to be rendered to said minor on the advice of, and under the general or special supervision of, a physician and/or surgeon licensed under the provisions of the Medical Practices Act, and to consent to any X-ray examination, anaesthetic, dental or surgical diagnosis, or treatment and hospital care, to be rendered to said minor by a dentist licensed under the provisions of the Dental Practices Act. For minor illnesses or injuries requiring medical treatment, Camp Chrysalis' staff will attempt to contact me before my child leaves the medical office. For major injuries or illnesses, they will attempt to contact me before institution of treatment, unless such treatment is so urgent that it must be done before contact can be made. If I cannot be reached, this authorization nevertheless is effective. I agree also to assume any financial responsibility for my child's care, resulting from consultation and/or treatment pursuant to this authorization. It is understood that this consent and authorization is given in advance, to enable Camp Chrysalis' personnel to authorize any specific diagnosis, treatment, or hospital care that may be required, in their best judgement and that of the aforementioned medical personnel.
2. I have read the memorandum titled Health Treatment Protocols. I understand that it covers a variety of conditions for which professional medical consultation and treatment are not usually or reasonably required; and the early stages of treatment of some conditions that may require further professional consultation and care. I hereby consent to any first-aid treatment, and to any treatment following these protocols, except for the restrictions I have itemized on the reverse of this sheet, which Camp Chrysalis staff may deem necessary or appropriate, in their best judgement, for my child's health and well-being.
3. I have received the memorandum titled Concerning Camp Chrysalis, covering camp practices. After reading it, and/or on other grounds, I am satisfied that my child's participation in camp will be directed and managed in a safe, orderly, and responsible manner by Camp Chrysalis staff. I agree that they individually and Camp Chrysalis shall not be held responsible for any injuries, illnesses, or other damages that might occur to my child or his/her possessions while entrusted to their care, save those following from their gross negligence in anticipatable circumstances. I understand that the Camp's risk coverage includes appropriate general liability insurance, and excess accident insurance covering medical costs beyond those reimbursed by family insurance, up to \$10,000.
4. I understand that enrollment in camp gives Camp Chrysalis permission to use pictures of my child for promotional and informational purposes in the brochure, website, slide show and other venues.

Please Sign and type all Information within this fillable form!

Parent/Guardian's signature: _____ Date: _____

Telephone(s): _____ (home) _____ (cell)

Parent's e-mails _____ Camper's e-mail _____

Other Emergency contact while at camp: _____

Pediatrician's name: _____ Pediatrician's Phone: _____

Health Insurance (Carrier and Number): _____

Date of Last tetanus shot _____