# WWS Summer Camp Emergency Contact & Medical Authorization Form

CAMPERS NAME: _____ DOB: _____

PRIMARY ADDRESS: _____

(1) PARENT/GUARDIAN NAME: _____
Cell Phone: _____ Work Phone: _____
Address (if different than campers):_____
Email: _____

(2) PARENT/GUARDIAN NAME: _____
Cell Phone: _____ Work Phone: _____
Address (if different than campers):_____
Email: _____

Additional Emergency Contact (if there is an emergency and the above contacts cannot be reached, the following person may be contacted and is/authorized to pick the child up from camp or from a camp activity in my/our stead):
Name: _____
Phone: _____Relationship: _____

## Medical Information

LIST ANY AND ALL MEDICATIONS (if medication needs to be administered at WWS a Maryland State School Medication Administration Authorization Form needs to be filled out and signed by a medical professional. Attach additional sheet if necessary). ☐ None

_____

ALLERGIES OR EXCEPTIONAL MEDICAL CONDITIONS (attach additional sheet or Action Plans if necessary particularly if camper has Asthma, Diabetes or Epilepsy). ☐ None

_____

MEDICAL PROVIDERS NAME/CONTACT INFORMATION:

_____

MEDICAL INSURANCE COVERAGE INFORMATION (Group/plan number):

_____

**RELEASE AND CONSENT:** I have provided the Washington Waldorf School, Inc. with all information regarding any medical conditions and/or allergies, and any regular medications taken by my child. I authorize and give permission for any Washington Waldorf School, Inc. employee to administer first aid, and/or to take or accompany my child to a physician or hospital for emergency treatment if it appears necessary in the judgment of the School. I understand that the School will utilize Emergency Medical Services (EMS) as it deems necessary and appropriate, and that EMS may transport my child to the most appropriate hospital in the area, at their discretion. I give consent for a licensed physician and/or the hospital and its medical staff to provide my child with emergency medical treatment which a physician deems necessary (including anesthesia). I agree to accept responsibility for all medical expenses incurred in the treatment of my child that are not covered by the Washington Waldorf School, Inc. student insurance policy.

PARENT/GUARDIAN SIGNATURE:_____ DATE: _____