Medical & Behavorial Information Form

We need further information about your student to plan appropriate education, healthy foods, and proper treatment in the event of any illness or injury. Please fill out all portions of this form and continue on back if necessary. This information will be kept confidential and shared only as needed with our staff and qualified medical personnel.

Participant name: _____ Date of birth: _____/_____/_____ (MM/DD/YY)
Please Print

Sex: M / F Height: ___ ft ___ inches Weight: ____ lbs

Insurance company: _____ Policy number: _____

Family doctor: _____Phone number of doctor: _____

Please attach photocopies of both sides of your insurance card or claim form.

MEDICATIONS:

Drug allergies & sensitivities: _____

Date of last tetanus booster: _____

Are immunizations up-to-date? **YES or NO** (If NO, please explain on back of this form)

Specific medications (prescriptions, over-the-counter, inhalers, etc.) student will require at Camp:

List kinds, frequencies, and reasons _____

YES or NO: My student may be offered over-the-counter medication for pain and allergies.

(CIRCLE any items you approve): acetaminophen (Tylenol); ibuprofen (Motrin, Advil); aspirin; Naproxen (Aleve); diphenhydramine (Benadryl).

Special concerns (asthma, vertigo, motion sickness, etc.): _____

DIETARY (Please be specific):

Restrictions: _____

Food allergies: _____

List any other food needs (vegetarian/vegan, etc.) _____

If "vegetarian," please elaborate (vegan?; do you eat dairy, fish, chicken?): _____

EMOTIONAL & BEHAVORIAL:

Discuss any tendencies that will help us relate to your student (ADHD, attention, social, etc.):

_____

I acknowledge that I have received and studied Astronomy Camp's COVID Policies will pickup my student within 24 hours of experiencing COVID symptoms. I agree to let my child be treated by a licensed physician while attending Astronomy Camp, as may be necessary, and to assume all costs related to such treatment. I authorize my insurance company to pay benefits to any medical facility or hospitals. Also, I authorize the disclosure of medical information to my insurance company for the purpose of claim. The above student has my permission to take the medications listed above as needed during the Camp.

Signature of parent/guardian (or participant if 18 or over)

_____ Date _____

Emergency Contact Information

Astronomy Camp Participant

(Last Name)	(First Name)	
(Mailing Address)		
(City)	(State)	(Zip)
(E-mail)	(Phone)	

Parent or Guardian / First Emergency Contact

(Last Name)	(First Name)	
(Mailing Address)		
(City)	(State)	(Zip)
(E-mail)	(Phone)	

Second Emergency Contact

(Last Name)	(First Name)	
(Mailing Address)		
(City)	(State)	(Zip)
(E-mail)	(Phone)	