Day Camp for the ARTS **CONFIDENTIAL HEALTH HISTORY AND CONSENT FORM**

Childs' First Name: _____Last: _____M☐ F☐

Address: _____ Home Phone: _____

Birth date: _____ Grade in Fall: _____ AGE: _____

Name of Parent/Guardian #1: _____ Address: _____

E-mail: _____ Cell Phone: _____ Work Phone: _____

Name of Parent/Guardian #2: _____ Address: _____

E-mail: _____ Cell Phone: _____ Work Phone: _____

EMERGENCY CONTACT—AUTHORIZED TO PICK UP CHILD:

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

MEDICAL CAREGIVERS (INFORMATION REQUIRED BY STATE LAW)

Family Physician: _____ Preferred Hospital: _____

Doctor's Phone: _____ Address: _____

Family Dentist: _____ Phone: _____ Address: _____

Medical Insurance: _____ Policy #: _____

List Allergies: _____Dietary Restrictions: _____

I hereby give consent to the Day Camp for the ARTS administrator to obtain all emergency medical or dental care prescribed by a duly licensed physician (M.D.). Osteopath (D.O.), or dentist (D.D.S.) for my child _____. This care may be given under whatever conditions are necessary to preserve the life, limb, or well-being of the above named child. The undersigned voluntarily signs this release and waiver of liability and indemnity agreement, and further agrees that no oral representations or statements, apart from this written agreement have been made.

_____ _____

Signature of Parent/Guardian **Date**