EAST PROVIDENCE RECREATION DEPARTMENT
EPRD SUMMER DAY CAMP MEDICAL FORM

PARTICIPANTS MUST RETURN THIS FORM COMPLETED BY:
PHYSICIAN & PARENT/GUARDIAN

RETURN TO: EPRD Summer Day Camp Program
610 Watermen, East Providence, RI 02914 / FAX: 435-1999

Please Type or Print Clearly

Participant's Name________________________________Birthdate___________________Sex________________

Address____Zip________________________

Home Phone____________________________________ Emergency Phone__________________________________

Medication(s) ______________________________________

Significant Condition(s)/Operation(s)/Illness____

Medical Information		**Explanations/Comments**
Allergies	Yes____ No____	________________________________
Seizures	Yes____ No____	________________________________
Dietary Restrictions	Yes____ No____	________________________________
Physical Limitations	Yes____ No____	________________________________
Hearing Loss	Yes____ No____	________________________________
Visual Complications	Yes____ No____	________________________________
Speech Difficulties	Yes____ No____	________________________________
Heart Difficulties	Yes____ No____	________________________________

May applicant participate in swimming activities? Yes_____ No_____

Needs to wear nose clip? Yes____ No_____ Can he/she dive? Yes____ No____

Needs to wear ear plugs? Yes____ No_____ Can he/she put face under water? Yes____ No____

Other Precautions: ____

Is participant, to your knowledge, suffering from or has he/she recently been exposed to any contagious disease?

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Physician's Signature____________________________________**Date**______________________________________

Physician's Address____**Phone**_____________________________

Parent/Guardian must complete the following:

In case of MEDICAL EMERGENCY I understand that every effort will be made to contact me. In the event that I cannot be reached, I hereby give permission to the East Providence Recreation Department to take such measures and arrange for such medical and hospital treatment as may be deemed advisable for the health and well-being of participant.

Signature of Parent/Guardian____**Date**_________________________