

**2010 Partners In Adventure Health Form Part 1**  
**General Information**

Camper's name \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Grade: \_\_\_\_\_  
Parent or Guardian \_\_\_\_\_  
Address \_\_\_\_\_  
Phone(H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_  
e-mail address \_\_\_\_\_  
Emergency Contact & Phone \_\_\_\_\_

**Health History**

Please list any allergies, dietary requirements and special needs

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If a parent /guardian cannot be contacted in an emergency, please contact:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Phone: Home \_\_\_\_\_ Work \_\_\_\_\_

In event of an emergency, do you give us your permission to contact your physician and /or seek emergency care? Yes No \_\_\_\_\_

signature

Will your child need to take medication during camp hours? \_\_\_\_\_ yes \_\_\_\_\_ no

Medication: (dosage, frequency & reason for medication):

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Medical diagnosis or disability

(please specify): \_\_\_\_\_

Physical aids:

\_\_\_\_\_ walker \_\_\_\_\_ wheelchair \_\_\_\_\_ crutches  
\_\_\_\_\_ braces \_\_\_\_\_ hearing aids \_\_\_\_\_ other (specify)

For camper with seizures or epilepsy:

Type of seizure \_\_\_\_\_

Receiving treatment: \_\_\_\_\_ yes \_\_\_\_\_ no On medication: \_\_\_\_\_ yes \_\_\_\_\_ no

Frequency of seizures: \_\_\_\_\_

Other information about

seizures: \_\_\_\_\_

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**Program Logistics**

We will have a trained lifeguard supervising all water activities:

Can your child swim? Yes No

Do you give permission for your child to participate in swimming & boating (seasonal) at camp?

Yes No \_\_\_\_\_

Signature

We will be transporting campers for off-site activities. Do you give permission for your

child to be transported? \_\_\_\_\_

Signature

Please return this completed form with your application to:

**Deborah Lamden, Partners In Adventure, Inc, P.O. Box 867, Shelburne, VT 05482**