Camper's Name: ________________________________Date of Birth:__________
Address:_____________________________________Phone Number:_________

2023 Form Valid for One Camper Only

This form will go with Emergency Personnel. Please fill out EVERY line!

OVER THE COUNTER MEDICATION PERMISSION AND MEDICAL HISTORY

I hereby give Loveland Sports & Academic Day Camp staff permission, *and also release all liability*, when applying or giving one or more of the following over the counter medications or external preparations, in accordance with the directions for use on the container (please check all that apply):
□Band-Aids □Sunscreen □Insect Repellent □Other: (please specify) ______________________________
Special Instructions:____

Parent/Guardian Signature: ____Date:____________

Current and past medical conditions for camper including all allergies, medications, medical concerns, chronic medical conditions, surgeries, broken bones, etc. (if "none" write NONE):
____

MEDICAL EMERGENCY TREATMENT CONSENT FORM

I give permission for Loveland Sports & Academic Day Camp to provide ALL necessary emergency medical, dental, or other care, including calling 911, for my camper. This care may be given under whatever conditions are necessary to preserve the life, limb or well-being of my dependent. The provider is required to try to contact me, the other parent or legal guardian at one of the below telephone numbers provided. At no time will the provider attempt to drive the sick or injured child to an emergency medical facility.

Parent/Guardian Signature:____ Date:__________

Parent/Legal Guardian: _______________________________________ Cell:_________________
Home Address:____
Place of Employment:____Work:_________________
Employment Address:____

Parent/Legal Guardian: _______________________________________ Cell:_________________
Home Address:____
Place of Employment:____Work:_________________
Employment Address:____

Emergency Contact (Friend or relative NOT living in the home):
Name:____Relationship: _______________
Address:____Cell:______________________
Place of Employment:__________________________________Work:______________________
Employment Address:____

Insurance Company:__________________________**Policy Number**:________________________
Physician:____Phone: ___________________________
Address:____

Hospital of Choice:
____MCR 2500 Rocky Mountain Ave, Loveland 80538 970-624-2500
____McKee Medical Center 2000 N Boise, Loveland 80538 970-820-4640
____Other:______________________________ Phone: _________________________________
Address:____

Dentist:____Phone:___________________________
Address:____