

**GREAT VALLEY NATURE CENTER  
TRAILROMPER & ELEMENTARY EXPLORER CAMP HEALTH FORM**

**\*\*(Adventure Camp has a separate health form.)\*\***

**PLEASE PRINT**

NAME \_\_\_\_\_ (A) BIRTHDATE \_\_\_\_\_ AGE \_\_\_\_\_  
 NAME \_\_\_\_\_ (B) BIRTHDATE \_\_\_\_\_ AGE \_\_\_\_\_  
 PARENT/GUARDIAN NAME(S) \_\_\_\_\_ CELL PHONE \_\_\_\_\_  
 ADDRESS \_\_\_\_\_ HOME PHONE \_\_\_\_\_  
 \_\_\_\_\_ WORK PHONE \_\_\_\_\_  
 PHYSICIAN/PEDIATRICIAN \_\_\_\_\_ PHONE \_\_\_\_\_

EMERGENCY CONTACTS (IF PARENTS ARE NOT AVAILABLE)

NAME & RELATION _____	NAME & RELATION _____
ADDRESS _____	ADDRESS _____
PHONE _____	PHONE _____

PLEASE ANSWER THE FOLLOWING QUESTIONS WITH A **YES** OR **NO** FOR EACH CHILD INDIVIDUALLY.

	NAME(A)	NAME(B)
DOES YOUR CHILD HAVE ANY SPECIAL HEALTH PROBLEMS THAT WOULD AFFECT PARTICIPATION IN CAMPS? PLEASE SPECIFY _____	_____	_____
DOES YOUR CHILD HAVE DIETARY RESTRICTIONS? PLEASE LIST _____	_____	_____
DOES YOUR CHILD TAKE ANY MEDICATIONS? PLEASE LIST _____	_____	_____
DOES YOUR CHILD HAVE ANY ALLERGIES TO MEDICATION? PLEASE LIST _____	_____	_____
IS YOUR CHILD ALLERGIC TO BEE STINGS OR OTHER INSECTS? IS SPECIAL MEDICATION NEEDED AND AVAILABLE? _____	_____	_____
MAY WE ADMINISTER BENADRYL IN THE CASE OF AN ALLERGIC REACTION?	_____	_____
MAY WE ADMINISTER TOPICAL MEDICINES (BEE STING OINTMENT, ANTISEPTIC, ETC.) TO YOUR CHILD IF NEEDED?	_____	_____

**PARENTAL PERMISSION TO PARTICIPATE AND CONSENT TO TREAT FOR MEDICAL EMERGENCIES: (MUST BE COMPLETED FOR CHILD PARTICIPATION)**

This health history is complete and I give permission for my child/children to participate in the Great Valley Nature Center's Camp. I understand that I will be contacted in case of sickness or accident. If I am unavailable for purposes of providing parental consent, I hereby authorize the Great Valley Nature Center and its staff to take my minor son/daughter to the nearest hospital for diagnostic procedures and medical treatment in the event of an emergency. I understand that I will be contacted during my child's examination in the emergency department when possible. If I am not available, please contact the physician listed on this form. I give permission for the Great Valley Nature Center's staff to provide first aid treatment in accordance with first aid approved protocols. A photocopy of this authorization shall be considered as effective and valid as the original.

**SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

Health Insurance Information:  
Name of Policy Holder \_\_\_\_\_

Health Insurance Company \_\_\_\_\_ Policy Number \_\_\_\_\_

We will assume that the above listed parents/guardians and emergency contacts are authorized for pickup unless otherwise notified. Please list the additional people who are authorized to pick up your child(ren). ANYONE (including parents) picking up should bring PHOTO ID every day!

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I give my permission to use my child's photograph in GVNC promotional materials.

**YES** (signature) \_\_\_\_\_

**NO** (signature) \_\_\_\_\_