2017

KEHOE-FRANCE CAMP
FIRST AID INFORMATION

______________________________ ________________________ ________
LAST NAME (Please print) FIRST NAME GRADE

________________________ ________________________ ________
HOME PHONE NUMBER BIRTH DATE AGE

____________________________________ ________________________________
MOTHER'S NAME FATHER'S NAME

WORK __________________ WORK __________________

CELL ___________________ CELL ___________________

E-MAIL __________________ E-MAIL _________________

PHYSICAN'S NAME____________________________ PHONE NUMBER_____________________

Do any of the following apply to your child. If so, please mark according.

Asthma______________ Inhaler in office_____________

Bug Bite Allergies____

Other Known Allergies________________________________EpiPen in Office_____________

Heart Problems____

Seizures or Convulsions____

Any medical condition we should be aware of in the best interest of your child?_________________________

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School may call the following persons if I cannot be reached should my child become ill or is injured.

____________________________________ ____________ ______________________
Friend/Relative **Relationship** **Phone Number**

____________________________________ ____________ ______________________
Friend/Relative **Relationship** **Phone Number**

In case of injury or serious illness, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to call and/or release my child(ren) to the persons indicated above. Please note that your child will not be released to anyone other than those above.

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Parent/Guardian