



STUDENT EMERGENCY CARD

Date: _____

Last Name		First Name	
Street Address			
City	State	Zip Code	
Primary Phone	Email		

Name of School	Birthdate	Grade
----------------	-----------	-------

Height		Weight		Chest Size		
Waist		Inseam		Shoe Size		
T-Shirt Size	<input type="checkbox"/> Small <input type="checkbox"/> Medium <input type="checkbox"/> Large <input type="checkbox"/> XLarge <input type="checkbox"/> 2XLarge					

Parent Information

Fathers Name	Mothers Name
Cell Phone	Cell Phone
Work Phone	Work Phone
Alternate Phone <small>(if applicable)</small>	Alternate Phone <small>(if applicable)</small>
Email	Email
Employed By	Employed By

Please Check One:

Student lives with:
 Both Parents
 Father
 Mother
 Guardian
 Other

Name of person with whom student lives, if not with parents: _____

Emergency Contacts

1st

Emergency Contact Name			
Relationship			
Cell Phone		Alternate Phone	
Email			

2nd

Emergency Contact Name			
Relationship			
Cell Phone		Alternate Phone	
Email			



STUDENT EMERGENCY CARD

Health History

Insurance Information

Insurance Carrier			
Policy #		Member #	
Medicaid?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Medicaid #	

Physician Name

Physician Office			
Name of Physician			
Office Number		Emergency Number	

Dietary Needs/Requirements: Yes No

If Yes... Vegetarian Gluten Free Vegan Other

If Other Explain _____

Allergies/Medications

Are you allergic to or do you have any adverse reaction to any of the following?

Yes	No	Allergy or Reaction	Explain	Tolerance
		Medication	Type: Action Plan:	<input type="checkbox"/> Intolerant <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
		Food	Type: Action Plan:	<input type="checkbox"/> Intolerant <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
		Plants	Type: Action Plan:	<input type="checkbox"/> Intolerant <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
		Insect Bites/Stings	Type: Action Plan:	<input type="checkbox"/> Intolerant <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
			Type: Action Plan:	<input type="checkbox"/> Intolerant <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
			Type: Action Plan:	<input type="checkbox"/> Intolerant <input type="checkbox"/> Moderate <input type="checkbox"/> Severe



STUDENT EMERGENCY CARD

List all medications currently used, including any over the counter medications.

Check here if NO medications are routinely taken.

Medication	Dose	Frequency	Reason

I give my permission for the Camp Ember staff to contact the prescribing physician regarding this medication.

Print Name of Parent / Guardian

Signature of Parent / Guardian

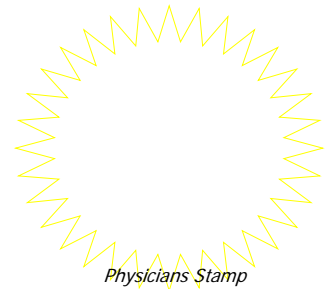
Date

Prescriptions Medications

Medication		Dosage	
Purpose			
Time(s) to be given:			

Signature of Physician

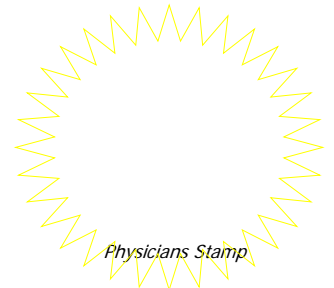
Date



Medication		Dosage	
Purpose			
Time(s) to be given:			

Signature of Physician

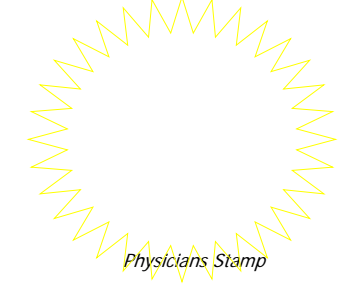
Date



Medication		Dosage	
Purpose			
Time(s) to be given:			

Signature of Physician

Date





STUDENT EMERGENCY CARD

PARENT / GUARDIAN AUTHORIZATIONS

Medical Release

In the event of an emergency, I understand that a reasonable effort will be made to contact me. If I cannot be reached, I hereby authorize a representative of Camp Ember to act on my behalf to seek emergency medical care or treatment for my child. I further give my permission to any physician or other qualified medical personnel to administer any and all emergency medical care, which they deem necessary. If I cannot be reached, I give my permission for any advisable medical services provided, and agree to accept liability for payment of those services.

MEDICATION AGREEMENT

I hereby request and give my permission to Camp Ember staff to administer medication to my child. I understand that it is my responsibility to provide the medication in the original pharmacy/or physician labeled container that has the correct medication dosage identified for my student. I also understand the camp may not alter or change any medications from their original form (cut or half pills, etc.)

Any prescription changes will require an additional signed and completed Medication Agreement.

Print Name of Parent / Guardian

Signature of Parent / Guardian

Date

Who will be picking up your student?

Contact Name			
Relationship			
Cell Phone		Email	



STUDENT EMERGENCY CARD

**Parent / Guardian
Information For You To Keep**

Pick up Information:

Sunday, June 2, 2018 at 12:00 Noon

West Metro Fire Rescue Training & Event Center

3535 S. Kipling Street

Lakewood, Colorado 80235

In the event of an emergency please contact:

Brooke Elder at 303-570-0493

Lakota Beckhorn at 302-547-3244