

*Please complete form in blue or black ink.*

Camp Participant Name \_\_\_\_\_

Date of Birth (month/day/year) \_\_\_\_\_ Age: \_\_\_\_\_ Camp Week: \_\_\_\_\_

Health/Accident Insurance Carrier Policy # _____ Group # _____
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Personal Physician \_\_\_\_\_ Physician's Phone \_\_\_\_\_

**PARENT, LEGAL GUARDIAN OR OTHER PERSON WHO HAS LEGAL AUTHORITY TO AUTHORIZE  
MEDICAL TREATMENT TO PARTICIPANT IN CASE OF EMERGENCY. PLEASE CONTACT:**

Name \_\_\_\_\_

Phone \_\_\_\_\_ Mobile \_\_\_\_\_

Please list any chronic or acute medical problems or special needs and explain so we can best accommodate your student's camp experience (*continue on separate sheet if needed*):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List any allergies to food, pollen or medicine: \_\_\_\_\_

\_\_\_\_\_

List any medications being taken at present: \_\_\_\_\_

\_\_\_\_\_

Does your child use an EPI Pen: Yes \_\_\_\_\_ No \_\_\_\_\_

I acknowledge the participant's immunizations are current: Yes \_\_\_\_\_ No \_\_\_\_\_

I or MY CHILD plan to attend FLORIDA INSTITUTE OF TECHNOLOGY CAMP, hereinafter referred to as "CAMP." I fully realize that injury or illness could result from or during MY or MY CHILD's participation in the CAMP. In case of accident or injury, I give my permission to receive medical treatment as deemed appropriate. I will assume responsibility for any medical bills.

Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_