CAMP WONDERKIN MEDICAL FORM

Participant Name _____ Age _____

Parent(s)/Guardian(s) Name _____

Primary Phone _____

Name of participants primary care physician _____

Contact number of primary care physician _____

Is the participant covered by insurance? _____

Name of insurance plan _____

Name of primary care holder on insurance _____

Is the participant suffering from any medical condition we should be aware of? _____

_____

_____

Is the participant allergic to anything we should be aware of? _____

_____

_____

In case of emergency whom should we contact? Full name and contact number

_____

*If there are any conditions or allergies you feel we should be aware of prior to the first day of camp please email us this information at info@littlewonderkin.com