goggleWorks Center for the Arts

201 Washington Street Reading PA 19601
610-374-4600 FAX 610-898-1908

# Medical Information

**First Name:**_________________________________**Last Name:**______________________________
**Date of Birth**____________

| **Physician's Name:** | **Physician's Phone Number:** |
|---|---|
| **Will your child be taking any medication during camp hours?**<br>**YES**____ **NO**_____ | **If Yes, What type?** |
| **Does your child have any allergies? Yes___ No___**<br>**If yes, please check the appropriate boxes:**<br>Bee Sting ☐<br>Peanuts/Nuts ☐<br>Drugs ☐<br>Food ☐<br>Other ☐ | **Please explain allergy in detail and what symptoms occur:**<br><br>**Please provide us with any dietary information necessary in an emergency situation:** |
| **Does your child have any chronic or recurring illness(es)?**<br>**Yes____No____**<br>**If Yes, What type?**<br>**Athsma__Diabetes__Seizuredisorder__Cardiac__**<br>**Other__________________** | **Please explain in detail:** |

**Please provide us with any additional information regarding your child's health or physical limitations:**

**Parent/Guardian Signature is required for each item below to indicate parental consent:**

| **Obtaining Emergency Medical Care:** | **Admin. Of Minor First Aid Procedures:** |
|---|---|
| | |

**Signature of Parent or Guardian**__________________________________________**Date**____________