WESTWOOD CROSS COUNTRY CAMP EMERGENCY INFORMATION

Camper Name Date of Birth

Address

City and State

Zip Code

Home Phone Cell Phone Work Phone

Age at Camp Sex M F

Physician Name

Physician Office Phone

Medical Insurance Company Policy Number

Medical Insurance Company Phone Number

This is to certify that the above camper has my permission to participate in all regular camp and swimming activities. I am aware of the physical nature and stresses required by the activities of this camp. I further certify that a physician has examined me or ward and I have been advised that I am approved for involvement in this camp's activities. In the event of an emergency, I give my permission to the camp medical staff to secure proper treatment at the local certified hospital for this staff member. The staff member/parent/guardian accepts responsibility for the medical bills.

Camper Signature: Date:

Camper Name (Please Print)

Parent/Guardian Signature (If staff member is under 18): Date:

Parent Guardian name (Please Print)