



POWERED BY SARASOTA MEMORIAL

Kids Camp Registration
Child Information and Health Assessment
(One form per child, children from same family must have their own form)

Camper Name: _____ DOB*: _____ Male / Female

*camper must turn 7 by the first day of camp and be under 13 years of age.

Email: _____

Address: _____

City: _____ State: _____ ZipCode: _____

Emergency Contact: _____ Relation to Child _____

Phone#1: _____ Phone #2: _____

Please list the names of any person and phone number who might be picking up your child:

- 1) _____ 2) _____
- 3) _____ 4) _____

- Is your child allergic to bee stings? Yes ___ No ___
- Is your child diabetic? Yes ___ No ___
- Does your child have high blood pressure? Yes ___ No ___
- Is there history of high blood pressure in your family? Yes ___ No ___
- Does your child have any limitations? Yes ___ No ___

If yes, please explain: _____

Food Allergies; List all food allergies for child;

Has your Child had any previous surgery? Yes ___ No ___
If yes, please explain: _____

Does your child have any medical problems not already listed? Yes ___ No ___
If yes, please explain: _____

Is your child taking any medications? Yes ___ No ___
If yes, please list them: _____

Parent/Guardian Release Statement:
This facility is not licensed, and is not required to be licensed, by the State of Florida. I understand that all due regard and proper safety precautions will be used. However, in the event that my child should be injured or lose personal property, I will not hold Rising Stars Childcare, Healthfit, Sarasota Memorial Hospital, or its childcare providers liable for that injury or property loss.

Signature of Parent/Guardian Date