

**INDIVIDUAL  
MEDICAL CARE FORM  
WINTER WEEKENDS 2024**

**Complete this form and return to your group leader accompanying you to the WINTER WEEKEND Please write so it can be read.**

**Name** \_\_\_\_\_

**Address** \_\_\_\_\_

**City** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Age** \_\_\_\_\_ **Sex:** M F **Grade** \_\_\_\_\_

**EMERGENCY CONTACT:** \_\_\_\_\_

**EMERGENCY CONTACT PHONE NUMBER:** \_\_\_\_\_

**Name of Group Leader** \_\_\_\_\_

**Please explain here if there are any special medical, allergy, or physical needs that we should be aware of during the WINTER WEEKEND:**

**I GIVE MY PERMISSION FOR MY FAMILY MEMBER LISTED ABOVE TO HAVE ROUTINE NON-SURGICAL MEDICAL TREATMENT AT THIS EVENT.**

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

**Parent/Guardian printed name:** \_\_\_\_\_

**PLEASE DO NOT MAIL THIS FORM TO THE CAMP. YOUR YOUTH LEADER OR ADULT CHAPERONE SHOULD HOLD ON TO THIS FORM DURING THE EVENT**