Travel Overnight Monday – Friday
Enjoy the weekends at home!

"…an experience you'll remember forever!"

PO Box 608 Huntington Village, NY 11743
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info@canteenroads.com

MEDICAL FORM

www.canteenroads.com

Please fill in as much of the information as possible. Your child is our first priority, the more information we have the safer they are.
In addition, make sure you attach a copy of your child's medical insurance.

Childs Name__________________________________ DOB_______________ SSN______________________

Home address____
STREET CITY STATE ZIP CODE

Parent/Guardian_______________________ Home phone ____________ Business phone____________ Cell phone____________

Medical Insurance________________________________ Group #____________________Policy #_________________________

Name of Insured____________________________________ Relationship to child____

Emergency Contact Information:

1. Name ____ Relationship_________________________________
   Home Phone_________________ Cell phone ___________________
   Address ____

2. Name____ Relationship_________________________________
   Home Phone_________________ Cell phone ___________________
   Address ____

Health History - Please check all that apply and provide dates of incidence.

Diseases/Conditions

- ☐ Ear infection________
- ☐ Diabetes____________
- ☐ Nose Bleeds_________
- ☐ Headaches___________
- ☐ Heart Condition______
- ☐ Rheumatic Fever_____
- ☐ Operations__________
- ☐ Mumps______________
- ☐ Convulsions_________
- ☐ Mononucleosis_______
- ☐ Chicken Pox_________
- ☐ Measles_____________

Allergies

- ☐ Food ____________
- ☐ Medication________
- ☐ Poison Ivy_________
- ☐ Insects____________
- ☐ Hay Fever_________
- ☐ Asthma___________

Additional details

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Permission to Treat

I hereby give Canteen Roads Teen Travel Camp and its representatives permission to take my child to any hospital facility or outside doctor when deemed necessary. In addition, I hereby give my permission to the physician selected by the director to secure proper treatment, order of x-rays and/or injection, anesthesia or surgery for my child as named above.

____
(Signature of Parent or Guardian)

____
(Date)

Credit Card Payment Authorization

*I hereby authorize Canteen Roads Teen Travel Camp and its representatives to charge medical treatment and medication for my child. Canteen Roads Teen Travel Camp may only use this credit card for medical treatment and medication for the duration of the child's summer program. (*This payment option is only used when the medical facility does not take insurance)

Type of card___________________________
Credit Card # __________________________
Name on card___________________________
Exp date_______________________________

____
(Signature of Parent or Guardian)

____
(Date)