CAMP CUPERTINO 2022

Participant Emergency and Identification information

PARTICIPANT INFORMATION

Participant Full Name: _____Birthdate: ___/___/____ Age: _____

Parent/Legal Guardian's Full Name: _____ Cell Phone: _____

Address: _____ City/Zip Code: _____ State: _____

E-mail: _____ Home Phone: _____

Parent/Legal Guardian's Full Name: _____ Cell Phone: _____

Address: _____ City/Zip Code: _____ State: _____

E-mail: _____ Home Phone: _____

THE FOLLOWING PEOPLE ARE AUTHORIZED TO PICK UP MY CHILD (THEY MAY BE CALLED IN CASE OF EMERGENCY):

Name	Phone	Relationship to Participant

PERSONS NOT AUTHORIZED TO PICK UP (IF APPLICABLE)

Name	Phone	Relationship to Participant

MEDICAL HISTORY

☐ Food Allergies ☐ Skin/Sunscreen Allergies ☐ Environmental Allergies ☐ Other

List dietary restrictions here: _____

List current medications and purpose here: _____

Does your child require special accommodations: No Yes, Please explain: _____

_____

_____

SIGNATURE

Parent/Guardian Signature: _____ **Date** _____

Quinlan Community Center | 10185 N. Stelling Road Cupertino, CA 95014
(408) 777-3120

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PARTICIPANT EMERGENCY CARD

PARTICIPANT'S NAME:_____ Age:_____ Date of Birth: _____

PARENT/GUARDIAN 1:_____ Relationship:_____

Address:_____ City/State/Zip:_____

Home Phone: _____ Cell Phone:_____

E-Mail:_____ Work Phone:_____

PARENT/GUARDIAN 2: _____ Relationship:_____

Address:_____ City/State/Zip:_____

Home Phone:_____ Cell Phone:_____

E-Mail:_____ Work Phone:_____

ALTERNATE PERSONS AUTHORIZED TO PICK UP (must be local):

Name:_____ Phone Number:_____ Relationship:_____

Name: _____ Phone Number: _____ Relationship:_____

PERSONS NOT AUTHORIZED TO PICK UP (if applicable):

Name(s):_____ Relationship:_____

MEDICAL HISTORY

Allergies:_____

List dietary restrictions here:_____

List current medications and purpose here:_____

Does your child require special accommodations? No Yes, Please explain: _____

_____

_____

PARENT/GUARDIAN SIGNATURE:_____ **DATE:**_____

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PERSONS NOT AUTHORIZED TO PICK UP (if applicable):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

MEDICAL HISTORY

Allergies: None Hay Fever Bee Stings Other insect Foods Pollen

Other Allergies: _____

List dietary restrictions here: _____

List current medications and purpose here: _____

Does your child require special accommodations? No Yes, Please explain: _____

_____

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

CUPERTINO

PERSONS NOT AUTHORIZED TO PICK UP (if applicable):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

MEDICAL HISTORY

Allergies: None Hay Fever Bee Stings Other insect Foods Pollen

Other Allergies: _____

List dietary restrictions here: _____

List current medications and purpose here: _____

Does your child require special accommodations? No Yes, Please explain: _____

_____

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

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