

**EAST PROVIDENCE RECREATION DEPARTMENT
SUMMER DAY CAMP REGISTRATION FORM**
PARTICIPANTS MUST RETURN THIS FORM COMPLETED BY:
PHYSICIAN & PARENT/GUARDIAN

**RETURN TO: EP Recreation Summer Day Camp Program
610 Waterman Avenue, East Providence, RI 02914 PH: 437-7511 / FAX: 4357803**

Please Type or Print Clearly

Participant's Name _____ Birthdate _____ Sex _____
 Address _____ Zip _____
 Home Phone _____ Emergency Phone _____
 Medication(s) _____
 Significant Condition(s)/Operation(s)/Illness _____

Medical Information

Explanations/Comments

Allergies	Yes ___ No ___	_____
Seizures	Yes ___ No ___	_____
Dietary Restrictions	Yes ___ No ___	_____
Physical Limitations	Yes ___ No ___	_____
Hearing Loss	Yes ___ No ___	_____
Visual Complications	Yes ___ No ___	_____
Speech Difficulties	Yes ___ No ___	_____
Heart Difficulties	Yes ___ No ___	_____

May applicant participate in swimming activities? Yes ___ No ___
 Needs to wear nose clip? Yes ___ No ___ Can he/she dive? Yes ___ No ___
 Needs to wear ear plugs? Yes ___ No ___ Can he/she put face under water? Yes ___ No ___
 Other Precautions: _____

Is participant, to your knowledge, suffering from or has he/she recently been exposed to any contagious disease? _____

Physician's Signature _____ Date _____
 Physician's Address _____ Phone _____

Parent/Guardian must complete the following:

In case of MEDICAL EMERGENCY I understand that every effort will be made to contact me. In the event that I cannot be reached, I hereby give permission to the East Providence Recreation Department to take such measures and arrange for such medical and hospital treatment as may be deemed advisable for the health and well-being of participant.

Signature of Parent/Guardian _____ Date _____