

**PLYMOUTH DAY CAMP**  
**Emergency Contact Information**

**Child:** \_\_\_\_\_

**Class:** \_\_\_\_\_

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

**Home telephone:** \_\_\_\_\_

**Mother's Name:** \_\_\_\_\_  
**Employer:** \_\_\_\_\_

**Cell Phone #:** \_\_\_\_\_  
**Telephone #:** \_\_\_\_\_  
**E-mail Address:** \_\_\_\_\_

**Father's Name:** \_\_\_\_\_  
**Employer:** \_\_\_\_\_

**Cell Phone #:** \_\_\_\_\_  
**Telephone #:** \_\_\_\_\_  
**E-mail Address:** \_\_\_\_\_

**Please list three persons to contact in case of emergency (other than parent):**

1. **Name:** \_\_\_\_\_ **Telephone #:** \_\_\_\_\_ **Cell Phone #:** \_\_\_\_\_  
**Relationship to Child:** \_\_\_\_\_

2. **Name:** \_\_\_\_\_ **Telephone #:** \_\_\_\_\_ **Cell Phone#:** \_\_\_\_\_  
**Relationship to Child:** \_\_\_\_\_

3. **Name:** \_\_\_\_\_ **Telephone #:** \_\_\_\_\_ **Cell Phone#:** \_\_\_\_\_  
**Relationship to Child:** \_\_\_\_\_

**Name of Physician and/or Hospital:** \_\_\_\_\_  
**Address:** \_\_\_\_\_ **Telephone #:** \_\_\_\_\_

**Please list any special medical conditions or allergies below. Please include treatment, if any:**

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**Please sign the statement below and return it to your child's teacher.**

**CONSENT FOR EMERGENCY MEDICAL TREATMENT (required for admission)**

**I do hereby give authority to the Plymouth Day Camp staff to obtain necessary emergency medical treatment for my child, with the understanding that the family will be notified as soon as possible.**

**SIGNED:** \_\_\_\_\_ **DATE:** \_\_\_\_\_  
**RELATIONSHIP:** \_\_\_\_\_