Summer Youth Program

Health Information

Child (children's) Name_____ _____

Last First Age

_____ _____

Birth Dates _____ _____

Parent or Guardian_____ Phone_____

Home Street Address_____ Work Phone_____

Emergency Contact_____ Phone_____

Is your child allergic to bees? _____ Any food allergies?_____

Any other allergies or concerns? _____

In case of an emergency, I give permission to the Johnsburg Youth Program to secure medical treatment for the above child (children). Every effort will be made to contact the parents or guardian in the event of an emergency.

Date _____ Signature_____