



**ICE AT THE GALLERIA  
2017 SUMMER CAMP  
MEDICAL/EMERGENCY CONTACT FORM**

PLEASE PRINT

Name: \_\_\_\_\_ Sex: M F  
Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
Parent's Name: \_\_\_\_\_ Email \_\_\_\_\_  
Home # \_\_\_\_\_ Mobile \_\_\_\_\_ Work # \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Doctor's Last Name: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Emergency Contact Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

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**ALLERGIES, MEDICAL PROBLEMS, MEDICATIONS, SPECIAL NEEDS, SPECIAL DIET,  
RESTRICTIONS ON ACTIVITY:**

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Is there any information about your child that will help us understand his/her needs better?

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I give permission, in case of injury, to the Ice at the Galleria to take my child to a hospital for treatment, to include evaluation of injury, x-rays, and needed care.

Date: \_\_\_\_\_ Parent's Signature: \_\_\_\_\_

Health Insurance Name: \_\_\_\_\_ ID#: \_\_\_\_\_