



## Camp Medical Form

Name of Camper: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

### **Emergency Contact**

Name: \_\_\_\_\_

Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Relation to Camper: \_\_\_\_\_

Does the camper have any allergies?

\_\_\_\_\_

Is the camper taking any medications during camp hours?

\_\_\_\_\_

Any other concerns?

\_\_\_\_\_

Please mail form to:

Yogi Berra Museum & Learning Center

8 Yogi Berra Drive

Little Falls, NJ 07424

Or fax to: (973)655-6894

Or email to: [yogimuseum@montclair.edu](mailto:yogimuseum@montclair.edu)