



*Come Play on Our River Day Camp*  
 263 Main Street, Doaktown, NB E9C 1A9  
 TEL: 506-365-7787 / FAX: 506-365-7359  
 Email: [comeplay@nb.aibn.com](mailto:comeplay@nb.aibn.com)  
 Facebook : *Come Play on Our River*

**CAMPER'S PROFILE**

CHILD'S FULL NAME: \_\_\_\_\_

NAME HE/SHE PREFERS TO BE CALLED: \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_  
 \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_

FULL NAME OF PARENT / GUARDIAN: \_\_\_\_\_

HOME ADDRESS (if different from that of the child's): \_\_\_\_\_  
 \_\_\_\_\_

TELEPHONE NUMBERS (including area code):

Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

CHILD'S MEDICARE NUMBER: \_\_\_\_\_

EXPIRATION DATE: \_\_\_\_\_

ALLERGIES: \_\_\_\_\_  
 \_\_\_\_\_

SPECIFY ANY MEDICATION YOUR CHILD TAKES ON A REGULAR BASIS:

\_\_\_\_\_  
 \_\_\_\_\_

*Please complete the Medications Release form if your child will be taking medication during camp week*

DOES YOUR CHILD SUFFER FROM ANY OF THE FOLLOWING?

- |                                   |   |   |
|-----------------------------------|---|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Asthma               |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> ADD / ADHD     | <input type="checkbox"/> Behavioral Disorders |

Are there other medical conditions of which we should be aware? \_\_\_\_\_  
 \_\_\_\_\_

Should your child be restricted from any of our camp activities? \_\_\_\_\_

IF YOUR CHILD WILL BE PICKED UP FROM CAMP BY SOMEONE OTHER THAN HIS/HER PARENT OR GUARDIAN, PLEASE PROVIDE THE FOLLOWING INFORMATION:

Person #1 \_\_\_\_\_

(Full Name)

\_\_\_\_\_  
(Relationship to Child)

\_\_\_\_\_  
(Contact Number)

Person #2 \_\_\_\_\_

(Full Name)

\_\_\_\_\_  
(Relationship to Child)

\_\_\_\_\_  
(Contact Number)

Person or persons **NOT** permitted to pick up your child: \_\_\_\_\_

EMERGENCY CONTACT: (1) \_\_\_\_\_

(Full Name)

\_\_\_\_\_  
(Phone Number where contact can be reached)

(2) \_\_\_\_\_

(Full Name)

\_\_\_\_\_  
(Phone Number where contact can be reached)

CHILD'S SWIMMING ABILITY:

\_\_\_ Excellent    \_\_\_ Satisfactory    \_\_\_ Poor

Last swimming lesson level completed (if applicable): \_\_\_\_\_