



Child's Full Name: \_\_\_\_\_

Parent's name & phone number:

\_\_\_\_\_

Camp Session Date(s) and Title(s): \_\_\_\_\_

Doctor's name, address & phone number:

\_\_\_\_\_

\_\_\_\_\_

Dentist's name, address & phone number:

\_\_\_\_\_

\_\_\_\_\_

Medication:

**PLEASE NOTE: WE CANNOT ADMINISTER ANY MEDICATION WITHOUT DOCTOR'S SIGNATURE! Please provide Four Mile Historic Park with signed permission from your child's doctor!!**

I consent to the administration of the following medications by staff of Four Mile Historic Park, Inc. (name of medications, dosage and frequency):

\_\_\_\_\_

\_\_\_\_\_

To be administered when necessary (please circle all that apply):

Tylenol          Benadryl          sunscreen          insect repellent  
inhaler          Epi pen          Other \_\_\_\_\_

As per parental instructions:

\_\_\_\_\_

\_\_\_\_\_

Doctor's signature: \_\_\_\_\_

To (camper name): \_\_\_\_\_

**Please send this and a copy of Certificate of Immunization to:**  
Four Mile Historic Park 715 South Forest Street, Denver, CO 80246 or fax to: 720-865-0801