



West Springs / Cougar Ridge
Community Association

PROGRAM – MEDICAL FORM AND AUTHORIZATION FOR PICKUP

MEDICAL OR HEALTH CONCERNS

Child's Name: _____ Age: _____

MEDICAL OR HEALTH CONCERNS:

Emergency Contacts:

1. Parent/Guardian Name: _____

Relationship to Child: _____

Phone # (H): _____ (C): _____ (W): _____

2. Parent/Guardian Name: _____

Relationship to Child: _____

Phone # (H): _____ (C): _____ (W): _____

AUTHORIZATION FOR PICK UP

Adults allowed to pick-up my child from camp (other than those listed above)

**ID verification will be required:

Name: _____ Phone: _____

Relationship to child: _____

Name: _____ Phone: _____

Relationship to child: _____



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Your signature below indicates the above information is complete and any medical concerns have been clearly discussed with the instructor.

Signature of Parent and/or Guardian: X:

Date: _____