Summer Camp Health Information Section

Must be forwarded 1 month before camp starts.

Please Attach Health Examination Form Provided by Child's Physician
And Dated Within Two Years or Less from Camp Week's Inception

In order to be informed of medical, physical or other needs/restrictions for your camper(s), parents are requested to complete the following form for each camper. If we should refer to the data provided on child's physician examination a copy of which you are attaching to this form, please state so.

Camper's Name: ____ Age: ________________

Weeks Attending Camp: ____

Parent /Guardian's Name: ____

Contact Number: ________________________ E-mail: ____

General Questions (Explain "yes" answers below)

Has/Did the participant:

1. Had any recent injury, illness or infectious disease? Yes No
2. Have a chronic or recurring illness/condition? Yes No
3. Ever been hospitalize? Yes No
4. Ever had surgery? Yes No
5. Have frequent headaches? Yes No
6. Ever had a head injury? Yes No
7. Ever been knocked unconscious? Yes No
8. Wear glasses, contacts or protective eye wear? Yes No
9. Ever had frequent ear infections? Yes No
10. Ever passed out during or after exercise? Yes No
11. Ever been dizzy during or after exercise? Yes No
12. Ever Had seizures? Yes No
13. Ever had chest pain during or after exercise? Yes No
14. Ever had high blood pressure? Yes No
15. Ever been diagnosed with a heart murmur? Yes No
16. Ever had back problems? Yes No
17. Ever had problems with joints? Yes No
18. Have an orthodontic appliance being brought to camp? Yes No
19. Have any skin problems? Yes No
20. Have diabetes? Yes No
21. Have asthma? Yes No
22. Had mononucleosis in the past 12 months? Yes No
23. Has a problem with diarrhea/constipation? Yes No
24. Have problems with sleepwalking? Yes No
25. If female, have an abnormal menstrual history? Yes No
26. Have a history of bed wetting? Yes No
27. Ever had an eating disorder? Yes No
28. Ever had emotional difficulties for which professional help was sought? Yes No

Please explain any "yes" answers, noting the numbers of the questions (use separate sheet of paper if necessary).

____
____
____

Which of the following did participant have?

Measles ____ Chicken Pox____ German Measles____ Mumps____ Hepatitis A_____ Hepatitis B____ Hepatitis C____

Please give all dates of immunization for (write N/A if vaccine does not apply):

Vaccine:	**Date(s) /month/yr of vaccinations**				
DTP:	______	_______	_______	_______	_______
TD:	______	_______	_______	_______	_______
Tetanus:	______	_______	_______	_______	_______
Polio:	______	_______	_______	_______	_______
MMR:	______	_______			
Or Measles:	______	_______			
Or Mumps	______	_______			
Or Rubella:	______	_______			
Haemophilus Influenza B	______	_______	_______	_______	
Hepatitis B:	______	_______	_______		
Varicella (chicken pox):	______	_______			

Special Needs Notification:

In order to be informed of medical, physical or other needs/restrictions for your camper(s), parents are requested to complete the following form for each registered camper. Please circle **no or yes**. Use back if more space is needed

Medical Allergies No Yes Describe: ____
Food Allergies No Yes Describe: ____
Activity Restrictions: No Yes Describe: ____

…/see back/…

Physical Restrictions No Yes Describe: ____
Diabetes No Yes Describe: ____
History of Seizures No Yes Describe: ____
Recent Surgeries No Yes Describe: ____
Other Conditions No Yes Describe: ____

Special Instructions related to allergies, bee stings, etc……

What is the child specifically allergic to?
____
____
____

Are you sending him or her with special medications/epi-pen/etc…? Yes No

Describe: ____

If yes, what do you want us to do in case of a related emergency?
____
____
____

Use this space to provide any additional information about the participant's behavior and physical emotional or mental health about which the camp should be aware.
____
____
____

*Name of family Physician*____*Phone:*________________________
Address: ____
*Name of family orthodontist/dentist*_________________________________*Phone:*______________________
Address: ____

If your child will be participating in a full day of camp, if you wish the child to participate in the swimming pool sessions, please indicate swimming ability/experience below.
Circle one*: Inexperienced /Beginner Moderately Experienced/ Novice Experienced/Advanced -*
____
____
____

<u>Emergency Information:</u>

*Contact # 1*____
Phone # 1 ____
Phone # 2 ____

*Contact #2*____
Phone # 1 ____
Phone # 2 ____

Health Waiver/ Permission to Treat

Name: ____

As the legal parent and/or guardian of ______________________, I grant permission to provide routine health care, administer prescribed medications and seek emergency medical treatment to my child in case of emergency

In the case of doctor prescribed medication, I will provide a written letter with instructions to the Office Manager

Signed: ____