

Day Camp Medical Form (please fill out completely)

This side is to be filled out by parent or guardian.

Name: _____ Birth Date: _____ Sex: _____ Age: _____
Last First Initial

Parent or Guardian Name: _____ Phone #: _____

Home Address: _____
No. & Street City State Zip

Business Address: _____
No. & Street City State Zip

If not available in an emergency, notify:

Name: _____ Phone #: _____

Address: _____ Relation: _____
No. & Street City State Zip

Health History: (check -- giving approximate dates where indicated)

Conditions:	Allergies:	Diseases:	Date
Frequent ear infections <input type="checkbox"/>	Asthma <input type="checkbox"/>	Mononucleosis	_____
Heart defect/disease <input type="checkbox"/>	Hay fever <input type="checkbox"/>	Chicken pox	_____
Convulsions <input type="checkbox"/>	Poison ivy <input type="checkbox"/>	Measles	_____
Diabetes <input type="checkbox"/>	Insect sting <input type="checkbox"/>	German Measles	_____
Bleeding/Clotting disorder <input type="checkbox"/>	Penicillin <input type="checkbox"/>	Mumps	_____

Prescription drugs taken on a regular basis: _____

Operations or serious injuries (dates): _____

Dietary Modifications: _____

Current Medications (send with instructions): _____

Other diseases or details of above: _____

Name of Dentist or Orthodontist: _____ Phone: _____

Name of Physician: _____ Phone: _____

Date of last physical examination: _____

Do you carry family medical/hospital insurance? _____

If so, indicate:

Carrier: _____ Policy or group #: _____

Suggestions or health related information for camp personnel: _____

For females:

Has this person menstruated: _____ If not, has she been told about it? _____

If so, is her menstrual history normal: _____ Special considerations: _____

IMPORTANT -- This box must be completed for attendance

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted.

Emergency Authorization: I hereby give permission to the medical personnel selected by the camp director to order x-rays, routine tests and treatment for me or my child, and in the event I cannot be reached in an emergency, I hereby give permission to the physician to hospitalize, secure proper treatment for, and to order injections or anesthesia and/or surgery for me/or my child as named above. This form may be for use out of camp.

Signature of parent or guardian: _____ Date: _____

I understand and agree to abide with the restrictions placed on my camp activities. Name of Minor: _____

Immunization Record

Required immunization must be determined locally. Please record the date (month/year) of basic immunizations and most recent boosters:

VACCINES	Date of Basic Immunization	Date of Last Booster
Diphtheria	1	1
Pertussis (Whooping Cough)	2	2
Tetanus	3	
DPT or		
Tetanus TD		
Diphtheria or		
Tetanus		
Oral polio (Sabin) TOPV Injectable Polio (Salk) Measles (hard measeles, red meaeles, Rubella		
Mumps		
Rubella (German Measeles or 3 Day Meaeles)		
Hepatitis B		
Haemphilus influenza B (mandatory for day camp)		
Varicella – chicken pox (not needed if child has had disease)		
Most recent Tuberculin test given (TINE)		
Other (specify):		

Physician's Signature: _____

Date: _____

MANDATORY PHYSICIAN FORM

INDIVIDUALIZED ORDERS for Camper: _____
 DOB: _____ Camp: _____

The following form must be completed and signed by the child's physician and attached to the registration form. This form must be filled out and signed for all campers.

Campers taking any prescription medications while at camp must be able to self-administer the medication under the supervision of the Camp Health Director/Designee. Camp Health Directors are only permitted to dispense medications that are listed on this form by the child's doctor.

Physician's Name: _____ Phone#: _____
 Address: _____ License#: _____
 Signature: _____ Date: _____

Standard Over the Counter/PRN Medications (The following medications are available and will be Administered at the discretion of the Health Director, if approval is indicated by the camper's Healthcare Provider.)

Drug Name	Route	Dosage and Schedule	Indications	Physician's Order	Comments
Antibiotic Ointment	Topical	Per label Instructions	Superficial Cuts/abrasions	Yes No	
Hydrocortisone Cream	Topical	Per label Instructions	Allergic Reactions, (contact dermatitis, insect bites)	Yes No	
Calamine Lotion (or Generic)	Topical	Per label Instructions	Allergic reactions (hives, insect bite)	Yes No	
Saline Solution/ Eye Wash		Per label Instructions	Dust/Sand In Eyes	Yes No	
Sting Stop	Topical	Per label Instructions	Insect bite	Yes No	
Wound Wipes/ Alcohol Wipes/ Iodine Wipes	Topical	Per label Instructions	Superficial Cuts/ Abrasions	Yes No	

Prescription Medications (Please complete with the patient's current regimen for both scheduled and PRN medications.): ***This includes Epi-Pen's, Ritalin, etc.***

Drug Name	Route	Dosage and Schedule	Indications	Camper Health Care Provider Order	Comments