

Camp Name: Philipstown Recreation Department

Camp Year:

2011

Mailing Address: PO Box 155, Cold Spring, NY 10516

Phone: 845-424-4618

Fax: 845-424-4686

Summer Camp Address: 107 Glenclyffe Drive, Garrison, NY 10524

REQUIRED MEDICAL HISTORY

(Parent or Legal Guardian to Complete)

Please Check One: () Returning Camper () New Camper () Returning Staff () New Staff

Name _____ **Date of Birth:** _____

Address _____ **Phone#:** _____

Emergency Notification:

With whom does child reside and what is / are his / her relationship(s) with the child? _____

Parent 1 Name _____ Home _____ Work _____ Cell _____

Parent 2 Name _____ Home _____ Work _____ Cell _____

Person to contact in an emergency if parents are unavailable:

Name _____ Home _____ Work _____ Cell _____

Physician: _____ Phone _____

Dentist/Orthodontist: _____ Phone _____

Emergency Medical Information (check yes or no)

Yes ___ **No** ___ Allergy to a medicine, food, plant, animal, or insect

Yes ___ **No** ___ Do you have an epinephrine pen?

Yes ___ **No** ___ Any condition that requires special care, medication or diet

Yes ___ **No** ___ Asthma

Yes ___ **No** ___ Contact Lenses

Yes ___ **No** ___ Seizure Disorder

Yes ___ **No** ___ Diabetes

Yes ___ **No** ___ Heart Trouble

Yes ___ **No** ___ Bleeding Disorder

Yes ___ **No** ___ Dentures

Yes ___ **No** ___ Bonded Teeth

Explain any of the above: _____

Medical History (check yes or no)

	<u>Yes</u>	<u>No</u>	<u>Date</u>	<u>Details</u>
Serious illness	_____	_____	_____	_____
Serious injury	_____	_____	_____	_____

Does your child have: (circle yes or no)

Y / N Heart Murmur

Y / N Rheumatic Fever

Y / N Stomach/Intestinal Problems

Y / N Menstrual Problems

Y / N Hernia

Y / N Back or Joint Pains

Explain any of the above: _____

Has this person had Chicken Pox? () Yes () No If yes, when? Date _____

Has this person had Mumps? () Yes () No If yes, when? Date _____

Has this person been exposed to a contagious disease within the past three weeks? _____

Has this person had lice in the past six months? _____

Does this person take any medication on a regular basis? Yes _____ No _____

Explain: _____

To the best of my knowledge, the above information is correct. I give my child permission to participate in all camp activities and trips. In the event of accident or illness, I authorize the Camp to institute and obtain medical care.

** In the event of a communicable disease outbreak, I understand this person will be excluded from camp if not fully immunized.

DATE _____ SIGNATURE (parent or legal guardian) _____

MEDICAL EVALUATION

(To be completed by physician or please attach a physical form from within the last year.)

Name: _____ Date of Birth: _____

Disease Assessment

Yes	No		Date of Onset
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Exercise Induced <input type="checkbox"/> unclassified
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/> Type I <input type="checkbox"/> Type II
<input type="checkbox"/>	<input type="checkbox"/>	Anaphylactic Reaction	<input type="checkbox"/> Food <input type="checkbox"/> Insect <input type="checkbox"/> Latex <input type="checkbox"/> Other: Explain
<input type="checkbox"/>	<input type="checkbox"/>	Seizure Disorder	Type:
<input type="checkbox"/>	<input type="checkbox"/>	Chicken Pox	If yes, when?
<input type="checkbox"/>	<input type="checkbox"/>	Mumps	If yes, when?
<input type="checkbox"/>	<input type="checkbox"/>	Other:	Please Specify

Immunization History (Please provide month, day and year of immunization)

Vaccine	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DPT / Hib						
DTaP						
DT / Td						
OPV						
IPV						
MMR						
HiB						
Hep B						
Hep A						
Varicella						
TDap						
PCV						
HPV						
MCV						

Emergency Medications:

Does this person require:

Epi-pen: yes no

PRN Inhaler: yes no

This person has permission to carry:

Epi-pen: yes no

PRN Inhaler: yes no

(Note: ability to carry implies ability to self administer)

HIPPA Privacy Statement: Permission to Release Confidential Health Information

I give _____ permission to release confidential health information to _____

Name of Medical Practice

Name of Camp

regarding this person _____.

Name of Camper

Date: _____

Parents/Guardian Signature: _____

I certify that I have on this date examined the above named camper and that on the basis of my examination and the medical history as furnished to me, I have found no reason which would make it medically inadvisable for this camper to participate in physically strenuous activities.

Signature of Physician _____ Date of Examination _____

Please Print: Physician's Name _____ License# _____

Address _____ Phone# _____

Parents Signature: _____ Date: _____