

# REQUIRED MEDICAL HISTORY (needed for day camp only)

Please attach physician's physical form (including immunizations) from within the last year.

Name \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address \_\_\_\_\_ Phone#: \_\_\_\_\_

### Emergency Notification:

#### 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 \_\_\_\_\_

### Sunscreen

My child has permission to carry and use sunscreen: Yes \_\_\_\_\_ No \_\_\_\_\_

### Emergency Medical Information (check yes or no)

Yes\_\_\_ No\_\_\_ Seizure Disorder      Yes\_\_\_ No\_\_\_ Diabetes      Yes\_\_\_ No\_\_\_ Heart Trouble

Yes\_\_\_ No\_\_\_ Bleeding Disorder      Yes\_\_\_ No\_\_\_ Asthma      Yes\_\_\_ No\_\_\_ Dentures

Yes\_\_\_ No\_\_\_ Contact Lenses      Yes\_\_\_ No\_\_\_ Bonded Teeth

Yes\_\_\_ No\_\_\_ Any condition that requires special care, medication or diet

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? \_\_\_\_\_

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

Explain: \_\_\_\_\_

### Emergency Medications

(Please note- All emergency medication requires a physician's written order. All medications must be in pharmacy prepared containers and labeled with the name of the child, name of the drug, strength, dose, frequency, physicians name and date of the original prescription)

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

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) \_\_\_\_\_