****AT LEAST ONE WEEK PRIOR TO PROGRAM RETURN COMPLETED FORM TO:****

This side to be completed by parent.

FOR: SUMMER CAMP(S)_____

Name _____ Birth date _____

Sex_____ Age _____

Last First Initial

Parent/Guardian (or Spouse) _____ Phone
(H)_____
(W)_____

Home Address

_____

Street & Number City State Zip
If not available in an emergency, notify:

1. _____ Phone
_____
Name Area Code and Number

_____

PERSONAL HISTORY: (circle condition you have had)
Alcohol Dependency Chicken Pox Heart Disease Rheumatic Fever
Allergy Diabetes Jaundice Scarlet Fever
Anemia Drug Dependency Kidney Disease Seizure Disorder
Asthma Eczema Pneumonia Tonsillitis
Bronchitis Emotional Problems/Counseling Recurrent Ear Infection
OPERATIONS, INJURIES AND HOSPITALIZATIONS (with dates)

_____
_____
_____
PRESENT MEDICATIONS OR
TREATMENTS_____
PLEASE LIST ALL ALLERGIES, INCLUDING ALLERGIES TO
MEDICATIONS_____
_____
_____
IMPORTANT: Please notify the camp if this camper is exposed to any communicable disease during the three weeks prior to camp attendance.

PERSONAL HEALTH INSURANCE CO.

_____

ADDRESS _____ ID#
_____

***PARENT AUTHORIZATION: This health history is correct so far as I know, and the person herein described has my permission to engage in all prescribed camp activities, except as noted by the**

examining physician and me. In the event I cannot be reached in an EMERGENCY I hereby give permission to the health care provider selected by the camp director to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child as named above.

PARENT SIGNATURE: _____ DATE: _____

REVISED 1-06

PATIENT NAME: **_____**

_____

LAST FIRST DOB

IMMUNIZATIONS REQUIRED FOR REGISTRATION *TETANUS-DIPHTHERIA TOXOID (BOOSTER WITHIN 10 YRS.) DATE*_____

Hib vaccine DATES 1st_____ 2nd _____ 3rd _____ 4th _____ OR date of illness _____

Hepatitis B vaccine DATES 1st_____ 2nd _____ 3rd _____

POLIO VACCINE (complete series of Oral/Salk)

DATES_____

MMR (Mumps, Measles, Rubella) (after 1st birthday) **DATES 1st_____**

2nd_____

OR

***MUMPS VACCINE (after 1st birthday) DATE _____**

***MEASLES VACCINE (after 1st birthday) (2 doses mandatory) DATES 1st_____**

2nd _____

***RUBELLA VACCINE (after 1st birthday) DATE _____**

OR

MUMPS TITER (valid only if lab report included) **RESULT_____**

DATE_____

MEASLES TITER (valid only if lab report included) **RESULT_____**

DATE_____

RUBELLA TITER (valid only if lab report included) **RESULT_____**

DATE_____

VARICELLA VACCINE DATE_____ OR DATE OF ILLNESS _____

MEDICAL EXAMINATION –TO BE FILLED OUT BY LICENSED PHYSICIAN, PHYSICIAN'S ASSIST/NURSE PRACTITIONER

This examination must be performed within 12 months of arrival at camp. Examination for some other purpose within this period is acceptable. Examination is for determining fitness to engage in strenuous activities.

CODE: - Satisfactory x Not Satisfactory (explain) O Not Examined

HGT. _____ WT. _____ B.P. _____

Eyes_____ Lungs_____

Glasses_____ Abdomen_____

Ears _____ Hernia _____

Nose _____ Extremities _____

Throat _____ Posture (spine)_____

Teeth _____ Skin _____

Heart _____ Allergy_____

Recommendations and restrictions while in camp:

Special Diet

_____

Medications (identify)

_____

Dispensing protocol

_____

Can this camper participate in unrestricted recreational activity?

If no, explain:

_____

Other:

_____
____

I have examined the person herein described and have reviewed his/her health history. It is my opinion that he/she is physically able to engage in camp activities, except as noted above.

Telephone_____

_____

Examining Physician/Physician's Assist./ Nurse Practitioner

Date _____ Address

_____