Camp Health History Form for Camper

Return this form by May 15 to:
Summer Trails Day Camp
P.O. Box 352 Granite Springs, NY 10527
office@summertrailsdaycamp.com 914-245-1776 (ph) 914-245-1683 (fax)

Camper Name Birth Date Age at Camp Gender M F

Parent/Guardian Name:

Home Address City State Zip Phone

Business Address City State Zip Phone

Second Parent/Guardian

Home Address City State Zip Phone

Business Address City State Zip Phone

Emergency Contact (non-parent) Phone #1 Phone #2

1.

2.

Physician

Address City State Zip Phone

Dentist/Orthodontist

Address City State Zip Phone

Insurance Information

Is the participant covered by family medical/hospital insurance? ☐ Yes ☐ No

If so, indicate carrier or plan name Group #

Prescribed Medications Being Taken

Please list ALL medications (over-the-counter & non-prescription drugs) taken routinely (during the camp day & at home). Prescription medications that are taken during the camp day should be kept it in the original packaging/bottle that identifies the prescribing physician, name of medication, dosage, and frequency of administration. Attach additional pages for more medications.

☐ This person takes NO medications on a routine bases OR ☐ This person takes medications as follows:

Med #1 Dosage Specific times taken each day

Reason for taking

Med #2 Dosage Specific times taken each day

Reason for taking

Identify any medications taken during the school year that participant does/may not take during the summer.

Provide information about the participant's behavior and physical, emotional, or mental health about which the camp should be aware. Attach additional page if needed.

Important- This box must be completed for attendance

Parent/Guardian Authorizations: This health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted.

I hereby authorize Summer Trails Day Camp Inc. to administer the Standard Over the Counter/PRN Medications named in this document to the above named if necessary.

I hereby give permission to the camp to provide routine health care, administer prescribed medications, apply sunscreen and tick and insect repellent, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

Signature of parent/guardian:_____

Print Name Date

Immunization History

Which of the following has the participant had?

- ☐ Measles
- ☐ Chicken Pox
- ☐ German Measles
- ☐ Mumps
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C

TB Mantoux Test if indicated
Date of last test
Result: ☐ Positive ☐ Negative

Please give all dates of immunization for:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP						
TD (tetanus/diphtheria)						
Tetanus						
Polio						
MMRV						
or measles						
or mumps						
or rubella						
or varicella						
Haemophilus influenza B						
Hepatitis B						

Health Examination by Licensed Physician

I have examined the above applicant. Date Examined:

In my opinion, the above applicant ☐ is ☐ is not able to participate in an active camp program

The applicant is under the care of a physician for the following condition(s):

Current treatment:

Explanation of any reported loss of consciousness, convulsion, or concussion:

Does applicant have epilepsy? Yes No Does applicant have diabetes? Yes No

Recommendations and Restrictions while at camp:

Any treatment to be continued at camp:

Any medically prescribed meal plan or dietary restrictions:

Any allergies (food, drugs, plants, insects, etc) and state reaction:

Additional information for health care staff at the camp:

Does applicant have a chronic or severe disability?

Standard Over the Counter/PRN Medications/ Epi-Pen & Albuterol

The first four medications are available in the infirmary and will be administered at the discretion of a RN. For Minors, approval by the minor's healthcare provider is required. If you have been prescribed an epi-pen or albuterol, doctor's orders must be written below in addition to submitting the medication with the appropriate label. All medication must be locked securely at the Health Center.

Drug Name	Circle Preferred Route	Dosage	Schedule/Indication	Physician's Order
Tylenol	PO/chewable, elixir or tabs	Per Label Age/Weight	Q4 hr prn pain/fever >___F	Yes No
Ibuprofen	PO/chewable, elixir or tabs	Per Label Age/Weight	Q6 hr prn pain/fever>___F	Yes No
Visine		Per Label Age	1-2 drops up to 4x day	Yes No
Benadryl		Per Label Age/Weight	5mg/kg/24hrs	Yes No
Epi-Pen				
Albuterol				

Licensed Physician's Signature	
Address	**Phone**
Name of person completing form	**Date of Form Completion**