



# HEALTH FORM 1

## Camper Health History Form – SUBMIT BY JUNE 15<sup>th</sup>

Page 1 (*Parent* Complete and Sign)

Camper Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Sex \_\_\_\_ Age \_\_\_\_

Camper Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Sex \_\_\_\_ Age \_\_\_\_

Camper Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Sex \_\_\_\_ Age \_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

Parent 1 \_\_\_\_\_ Day Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Parent 2 \_\_\_\_\_ Day Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

If not available in an emergency, notify the following:

Name \_\_\_\_\_ Day Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ OR

Name \_\_\_\_\_ Day Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

**HEALTH HISTORY: (provide dates where applicable)**

First Name of Camper	Allergies												Diseases				
	Ear Infections	Rheumatic Fever	Convulsions	Diabetes	Hay Fever	Poison Ivy, etc	Insect Stings (Severe Reaction)	Penicillin	Iodine	Shellfish	Peanuts	Tree Nuts	Other Drugs/Food	Chicken Pox	Measles	Mumps	Asthma

Due to allergies, does your child(ren) require an epi-pen? Yes \_\_\_\_ No \_\_\_\_ Child's Name: \_\_\_\_\_

Has your child(ren) been diagnosed with any mental, behavioral, or emotional conditions? If so, will this limit any activities we offer at camp? (Please explain): \_\_\_\_\_

Does your child(ren) have any dietary restrictions or special food needs? (Please explain): \_\_\_\_\_

**EMERGENCY RELEASE - DEERKILL MUST HAVE THIS RELEASE RETURNED BEFORE THE START OF CAMP!!!**

This health history is correct so far as I know, and the persons herein described have permission to engage in all prescribed camp activities, except as noted by me and the examining physician. In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child(ren) as named above.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**We will use your physician if available but your signature is required by the 1st day of camp, per the NYS DOH.**



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Page 2 (*Physician* Complete and Sign)

**IMMUNIZATION HISTORY:** Please record the date (month and year) of basic immunizations and the most recent booster doses. The Department of Health will not accept records without dates.

<u>Vaccines</u>	<u>Date of Basic Immunization</u>			<u>Date of Last Booster</u>		
	Camper	Camper	Camper	Camper	Camper	Camper
Hepatitis B						
Diphtheria, Tetanus Pertussis (DtaP)						
Haemophilus Influenzae Type b (Hib)						
Polio (IPV)						
Measles, Mumps, Rubella						
Varicella (Chicken Pox)						

**MEDICAL EXAMINATION:** To be filled out by a licensed physician. This examination should be performed within 10 months of arrival at camp. Examination is for determining fitness to engage in strenuous activities. Examination for some other purpose within this period is acceptable. Parents may also provide an attached examination record signed by a licensed physician.

<u>Name of Camper</u>	<u>Height</u>	<u>Weight</u>	<u>Hgb Test</u>	<u>B.P.</u>	<u>Urinalysis</u>

Specify, with the camper's first name, any allergies, special diet, activity restrictions or special medicine required:

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I have examined the person(s) 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.

Date of Examination \_\_\_\_\_ Examining Physician \_\_\_\_\_ MD

Telephone \_\_\_\_\_ Address \_\_\_\_\_