



2010 Camper Medical & Emergency Information
Return form by May 1st

SIDE A: TO BE COMPLETED BY PARENT OR GUARDIAN

Please Note: No camper will be permitted to attend Camp until this form is completed in full!

Camper: Age Group: Group: To Be Determined

HEALTH INFORMATION: to be completed by parent or guardian

Is your child in normal good health? Yes No
Are there any restrictions from activity? Yes No
If Yes, Specify
Does your child have any allergies/seizures/ hypersensitivities? Yes No
If Yes, Specify
Does your child receive medication for allergies/seizures/hypersensitivities or any other reason? Yes No
If Yes - Please Specify
Is your child recommended for complete, normal activities? Yes No
If No - Please Specify

Pediatrician Name: Phone:

Sign Here Signed Relationship

EMERGENCY TREATMENT RELEASE: to be completed by parent or guardian

In the event the parent(s) or guardian(s) of my child cannot be reached during a medical emergency, I give permission for the physician listed above to direct the treatment given to my child. Should that physician not be available during a medical emergency, I give permission for the physician chosen by Purchase Day Camp to direct the treatment given to my child.

Sign Here Signed Relationship

SUNSCREEN PERMISSION: to be completed by parent or guardian - optional

Please re-apply the sunscreen I have supplied on a daily basis after swimming during the camp season.

Sign Here Signed Relationship

OTHER PROVIDERS: (Psychologist, Allergist, E.N.T., Dermatologist, Orthopedist, etc.)

Name: Phone: Specialty:
Name: Phone: Specialty:
Name: Phone: Specialty:

*** Please Have Physician Complete Reverse Side ***



SIDE B: TO BE COMPLETED BY PHYSICIAN

Note: If your doctor provides you with a different examination form, staple it to this page.

Camper: _____

Exam Date: ___/___/___

Is the camper in normal good health?..... **Yes No**

Are there any restrictions from activity?..... **Yes No**

If Yes, Specify _____

Does the camper have any hypersensitivities/allergies/seizures disorder?..... **Yes No**

If Yes, Specify _____

Does the camper receive medication for hypersensitivities/allergies/ seizures or any other reason?. **Yes No**

If Yes - Please Specify _____

Is the camper recommended for complete, unrestricted activities?..... **Yes No**

If No - Please Specify _____

PHYSICAL EXAMINATION
(Blank if Normal)

PAST MEDICAL HISTORY
(Blank if Normal)

Skin _____
 Eyes _____
 Ears _____
 Nose _____
 Heart _____
 Lungs _____
 Other _____

IMMUNIZATION RECORD

	Initial	Booster
Measles Vaccine	_____	_____
Mumps Vaccine	_____	_____
Rubella Vaccine	_____	_____
MMR	_____	_____
Hepatitis B	_____	_____
Diphtheria	_____	_____
Other	_____	_____

	Initial	Booster
Polio Vaccine	_____	_____
Tuberculin Test	_____	_____
Tetanus Toxoid	_____	_____
Hib Vaccine	_____	_____
Varicella (Chicken Pox)	_____	_____
DTP	_____	_____
Other	_____	_____

**Doctor's
Signature**

_____ **Date** _____

Required if using this form instead of Doctor's Form

***** Parents: Please Complete Reverse Side *****