



# 2011 Camper Medical Information

Return form by May 1<sup>st</sup>

**SIDE A: TO BE COMPLETED BY PARENT**

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

**Camper:**

**Age Group:**

**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:** (Allergist, E.N.T., Psychologist, Orthopedist, Dermatologist, 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**

	<b>Initial</b>	<b>Booster</b>
Measles Vaccine	_____	_____
Mumps Vaccine	_____	_____
Rubella Vaccine	_____	_____
MMR	_____	_____
Hepatitis B	_____	_____
Diphtheria	_____	_____
Other	_____	_____

	<b>Initial</b>	<b>Booster</b>
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 \*\*\***