

CAMP EMETH HEALTH AND SAFETY FORM



**The information on this form is gathered to assist us in identifying appropriate care for your child.
 The more information we have the better able we are to insure a safe and healthy summer.
 This form is to be completed by the parents/guardians of campers.
 NO DOCTOR VISIT REQUIRED.**

Name Last _____ First _____ Middle _____

Home Address _____
Street City State Zip

Camper Gender: Male Female **Birthdate** _____ **Age at Camp** _____

Custodial parent/guardian _____ **Home Phone** _____

Cell Phone _____ **Work Phone** _____ **Parent Email Address** _____

Address (if different from above) _____
Street City State Zip

Second parent or guardian or emergency contact _____

Address _____
Street City State Zip

Home Phone _____ **Cell Phone** _____ **Work Phone** _____

If not available in an emergency, notify _____ **Relationship** _____

Home Phone _____ **Cell Phone** _____ **Work Phone** _____

Insurance Information: Is the participant covered by family medical/hospital insurance? Yes No

If so, indicate carrier plan or name _____ **Group/ID #** _____

IMPORTANT --- THESE BOXES MUST BE COMPLETE 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 give permission to the camp to provide routine health care, administer prescribed medications 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 or adult camper/staff _____
Printed Name _____ **Date** _____

I also understand and agree to abide by any restrictions placed on my participation in camp activities.

Signature of minor or adult camper/staffer _____ **Date** _____

***If for religious reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance.**

HEALTH HISTORY

ALLERGIES – If your child has life-threatening food allergies, you will need to complete the Allergy information sheet and Allergy Action Plan in addition to this Health and Safety form.

Medication Allergies (list)

Describe reaction and management of the reaction.

Food Allergies (list)

Other Allergies (list) - include insect stings, hay fever, asthma, animal dander, etc.

PRESCRIPTION MEDICATION BEING TAKEN

Please list all prescription medicines, all prescription medication to be taken at camp must be kept in the original packaging/bottle that identifies the prescribing physician, the name of the medication, the dosage and the frequency of administration.

___ **This person takes NO medications on a routine basis.**

___ **This person takes medications as follows:**

Med # 1 _____ **Dosage** _____ **Specific time each day** _____
Reason for taking _____

Med #2 _____ **Dosage** _____ **Specific time each day** _____
Reason for taking _____

Attach additional pages for more medications or information about side affects.

I give permission to the Camp Director and/or Unit Directors to dispense any medication as needed. ___ **YES** ___ **NO**

OVER THE COUNTER MEDICATION BEING TAKEN

MY CHILD MAY BE GIVEN THE FOLLOWING OVER THE COUNTER MEDICATIONS (SUCH AS HEADACHE RELIEF, COUGH DROPS, DECONGESTANTS- PLEASE BE SPECIFIC): _____

PLEASE NOTE: You must list all medications you approve. If a specific OTC medication is not listed above, our staff will not dispense that medication to your child.

DIETARY RESTRICTIONS

Does not eat _____ **Red meat** _____ **Fish** _____ **Eggs** _____ **Poultry** _____ **Dairy products**

___ **Kosher (please note: Kosher food may not be available)** ___ **Other (describe)** _____

Explain any restrictions to activity (e.g., what cannot be done, what adaptations or limitations are necessary):

GENERAL QUESTIONS - Explain "yes" answers below

Has/does the participant:

	Yes	No		Yes	No
Had any recent injury, illness or infectious disease?	_____	_____	Ever had treatment for drug/alcohol abuse?	_____	_____
Have a chronic or recurring illness/condition?	_____	_____	Have a history of smoking?	_____	_____
Ever been hospitalized?	_____	_____	Ever had problems w/joints (knees, ankles)?	_____	_____
Ever had surgery?	_____	_____	Have an orthodontic appliance being brought?	_____	_____
Have frequent headaches?	_____	_____	Have any skin problems (e.g. itching, rash)?	_____	_____
Ever had a head injury?	_____	_____	Have diabetes? (Date of onset)	_____	_____
Ever been knocked unconscious?	_____	_____	Have asthma? (Date of onset)	_____	_____
Wear glasses, contacts or protective eyewear?	_____	_____	Have mononucleosis in the past year?	_____	_____
Ever had frequent ear infections?	_____	_____	Had problems w/diarrhea/constipation?	_____	_____
Ever passed out during or after exercise?	_____	_____	Have problems with sleepwalking?	_____	_____
Ever been dizzy during or after exercise?	_____	_____	Have a history of bed-wetting?	_____	_____
Ever had seizures/convulsions?	_____	_____	Ever had an eating disorder?	_____	_____
Ever had chest pain during or after exercise?	_____	_____	Ever had emotional difficulties for which professional help was sought?	_____	_____
Ever had high blood pressure?	_____	_____	Ever been diagnosed with ADD/ADHD?	_____	_____
Ever been diagnosed with a heart murmur?	_____	_____	Ever been diagnosed with depression?	_____	_____
Ever had back problems?	_____	_____			
Ever had epilepsy?	_____	_____			

Please explain any "yes" answers, noting the number of the question being addressed.

Which of the following has the participant had?

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

PLEASE SEND A COPY OF THE MOST RECENT IMMUNIZATION RECORD ALONG WITH THIS FORM.

Use this space to provide any additional information about your child's behavior and physical, emotional or mental health about which the camp should be aware. _____

I prefer my child be taken to _____ hospital, located on _____.

Name of family physician _____

Address _____ Phone Number _____

Name of family dentist/orthodontist _____

Address _____ Phone Number _____

PLEASE COMPLETE THIS FORM IN ITS ENTIRETY, INCLUDING ALL SIGNATURE LINES. IT IS ALSO IMPORTANT THAT YOU PLEASE WRITE LEGIBLY. WE WILL NOT BE ABLE TO ALLOW YOUR CHILD TO START CAMP IF THIS FORM*, AND THEIR IMMUNIZATION RECORDS ARE NOT RECEIVED WITH THEIR ENROLLMENT PACKET. *If your child will be taking medication during camp please include the completed Medication Consent Form.

THANK YOU IN ADVANCE FOR YOUR HELP WITH THIS IMPORTANT PART OF REGISTRATION.