

# CAMP PALATINE

## Camper's Health and Medical Summary

This section to be filled out by parent or guardian  
*Print in ink.*

Camp Program 2007

Name of Camper: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_  
 Parent/Guardian \_\_\_\_\_ Bus. Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
 Home Address: \_\_\_\_\_ City \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Business Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

If the **above person is unavailable**, in the event of an **emergency**, notify:

Name: \_\_\_\_\_ Relationship \_\_\_\_\_ Telephone: \_\_\_\_\_  
 Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Telephone: \_\_\_\_\_  
 Camper's personal physician: \_\_\_\_\_ Telephone: \_\_\_\_\_  
 Physician Address: \_\_\_\_\_

Personal Health/Accident Insurance Carrier: \_\_\_\_\_ Policy No.: \_\_\_\_\_

-----  
 In case of an emergency I understand that every effort will be made to contact me. In the event I cannot be reached, I hereby give my permission to the physician selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery or injections of medication for my child.

Signature of parent /guardian: \_\_\_\_\_ Date: \_\_\_\_\_  
 -----

Medical History Past/Present (circle response):

<u>Asthma</u>	Yes	No	<u>Heart Disease</u>	Yes	No	<u>Leukemia</u>	Yes	No
<u>Allergies</u>	Yes	No	<u>High Blood Pressure</u>	Yes	No	<u>Cancer</u>	Yes	No
<u>Convulsions</u>	Yes	No	<u>Diabetes</u>	Yes	No	<u>Hemophilia</u>	Yes	No
<u>Other (Explain)</u>	Yes	No						

Special Instructions:

Allergies: Food Yes No Medication Yes No Plants Yes No  
Insect Bites Yes No Other Yes No

Explanations/Special Instructions:

Should any activity be restricted (includes swimming, hikes, backpacking, physical games)?

List any conditions limiting full participation (physical or emotional)?

# CAMP PALATINE

## Camper's Health and Medical Summary

Parent/Guardian please note:

1. Medications will not be dispensed by counselors/EMT.
2. Campers will not be allowed to self medicate.
3. Medications (Prescription and/or over the counter) will not be permitted with the camper.
4. To discuss this camper's needs please speak to the Camp Director/Person in Charge at 518-537-6687.
5. Epipen Use: please speak to Camp Director/Person in Charge at 518-537-6687.

An annually up-dated form must be on file for each camper. If your child has seen a physician within the last year verify with a copy of the latest signed medical form. Records of immunizations must include those listed on this form.

This section to be completed by Physician, Physician's Assistant or Nurse Practitioner.

### Medicines and Immunizations:

Does this camper need to take regularly scheduled medications?      Yes      No

Will the parent/guardian be able to give this camper his/her medication before and/or after camp hours?      Yes      No

Any special equipment needed by this camper (Orthopedic or Handicap Devices, Glasses or Contacts, Dentures, Hearing Aides, etc.)? Describe:

List the dates next to the immunizations received by this camper:

*If one or more of the required medical immunizations is deemed detrimental to this child's health, attach certificate specifying which immunization(s) and complete and sign medical exemption statement.*

### Medical Exemption:

The physical condition of the above named child is such that immunization would endanger life or health.

Physician Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Hepatitis B Birth - 2 months 2 - 4 months 6 - 18 months *11 - 12 years	HIB 2 months 4 months 6 months 12 - 15 months
DTP 2 months 4 months 6 months	IPV 2 months 4 months 6 - 18 months 4 - 6 years
DTP Booster 15 - 18 months 4 - 6 years	MMR 12 - 15 months 4 - 6 years
Tetanus 11 - 12 years 14 - 16 years	Varicella 12 - 18 months *11-18 years

Other: (Prevnai)

\* Children who have not received these immunizations should be immunized.

Additional instructions to camp staff:

Signature of Examiner:

Address:

Name (please print):

City:

State:

Zip:

Title:

Phone:

Date: