



CAMPER HEALTH FORM

Please return fully completed form (both sides) no later than April 1st

PO Box 176, Ringwood, New Jersey 07456 • (973) 831-9000 office • (973) 831-9174 fax

Each camper MUST have a fully completed medical form for the CURRENT CAMP YEAR or will not be admitted to camp.

This side to be completed by parent/guardian. Please print/type. Return fully completed form (both sides) to above address.

Name _____ Birth Date _____ Age at Camp _____ M F
Last First M.I.

Siblings at Camp _____

Parent/Guardian _____ Home Phone () _____

Home Address _____ City _____ State _____ Zip _____

Bus. Phone () _____ Cell Phone () _____ Fax () _____

Second Parent/Guardian _____ Home Phone () _____

Home Address _____ City _____ State _____ Zip _____

Bus. Phone () _____ Cell Phone () _____ Fax () _____

IF PARENT IS NOT AVAILABLE IN AN EMERGENCY, CHILD MAY BE RELEASED TO: Name _____

Relationship _____ Home Phone () _____ Cell Phone () _____

Name of Dentist/Orthodontist _____ Phone () _____

Health Insurance Carrier _____ Phone () _____ ID# _____ Group # _____

GENERAL QUESTIONS: Please explain "yes" answers below.

- | | Yes | No | Yes | No |
|--|--------------------------|--------------------------|---|---|
| Has/does the participant: | | | | |
| 1. Had any recent injury, illness or infectious disease? | <input type="checkbox"/> | <input type="checkbox"/> | 13. Ever had frequent ear infections? | <input type="checkbox"/> <input type="checkbox"/> |
| 2. Have a chronic or recurring illness / condition? | <input type="checkbox"/> | <input type="checkbox"/> | 14. Ever had chest pain during or after exercise? | <input type="checkbox"/> <input type="checkbox"/> |
| 3. Have asthma? | <input type="checkbox"/> | <input type="checkbox"/> | 15. Ever passed out during or after exercise? | <input type="checkbox"/> <input type="checkbox"/> |
| 4. Ever been hospitalized? | <input type="checkbox"/> | <input type="checkbox"/> | 16. Ever been dizzy during or after exercise? | <input type="checkbox"/> <input type="checkbox"/> |
| 5. Ever had surgery? | <input type="checkbox"/> | <input type="checkbox"/> | 17. Ever had high blood pressure? | <input type="checkbox"/> <input type="checkbox"/> |
| 6. Ever had a head injury? | <input type="checkbox"/> | <input type="checkbox"/> | 18. Ever been diagnosed with a heart murmur? | <input type="checkbox"/> <input type="checkbox"/> |
| 7. Ever lost consciousness for any reason? | <input type="checkbox"/> | <input type="checkbox"/> | 19. Ever had back problems? | <input type="checkbox"/> <input type="checkbox"/> |
| 8. Have frequent headaches? | <input type="checkbox"/> | <input type="checkbox"/> | 20. Ever had problems with joints (e.g., knees, ankles)? | <input type="checkbox"/> <input type="checkbox"/> |
| 9. Ever had seizures? | <input type="checkbox"/> | <input type="checkbox"/> | 21. Have any skin problems (e.g., itching, rash, acne)? | <input type="checkbox"/> <input type="checkbox"/> |
| 10. Wear glasses, contacts or protective eyewear? | <input type="checkbox"/> | <input type="checkbox"/> | 22. Had problems with diarrhea/constipation? | <input type="checkbox"/> <input type="checkbox"/> |
| 11. Have an orthodontic appliance being brought to camp? | <input type="checkbox"/> | <input type="checkbox"/> | 23. If female, have an abnormal menstrual history? | <input type="checkbox"/> <input type="checkbox"/> |
| 12. Have diabetes? | <input type="checkbox"/> | <input type="checkbox"/> | 24. Ever had an eating disorder? | <input type="checkbox"/> <input type="checkbox"/> |
| <i>If yes, health care provider orders signed by a doctor must be submitted.</i> | | | 25. Ever had emotional difficulty for which professional help was sought? | <input type="checkbox"/> <input type="checkbox"/> |
| | | | 26. Ever receive special services during the school year? | <input type="checkbox"/> <input type="checkbox"/> |

Please explain any YES answers! _____

IMPORTANT: THIS AREA MUST BE COMPLETED! I hereby give permission to the medical personnel selected by the camp director to provide routine health care; to administer medications; to order X-Rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

- I do do not give permission for the camp nurse to administer Tylenol® (acetaminophen) if necessary.
- I do do not give permission for the camp nurse to administer Advil® (ibuprofen) if necessary.

Nursing staff may not administer ANY other medications without a doctor's order including over-the-counter items such as ear drops, cortisone cream, etc.

Spring Lake Day Camp is licensed by the New Jersey State Department of Health, and is inspected annually. Inspection reports are filed in the Camp office.

NAME OF PARENT/GUARDIAN (PRINT) _____ DATE _____

SIGNATURE OF PARENT/GUARDIAN _____

THIS SIDE TO BE COMPLETED BY PHYSICIAN: Please print legibly or type

Spring Lake Day Camp • PO Box 176 • Ringwood, New Jersey 07456 • (973) 831-9000 office • (973) 831-9174 fax

Camper's Name _____ Birth Date _____

I examined this individual on _____. (ACA accreditation requirements specify exams within 12 months of camp attendance.)

BP_____ Weight_____ Height_____ In my opinion, the above camper is is not able to participate in an active camp program.

The camper is under the care of a physician for the following condition(s): _____

If camper has diabetes, health care provider orders for diabetes maintenance must be submitted.

IMMUNIZATIONS (Please indicate month/year)

DPT						
TD						
MMR						
HiB						
Hepatitis B						
Varicella (chicken Pox)						
Polio						

Has the camper had any of the following:

- Measles Chicken Pox Mumps
- German Measles Hepatitis A Hepatitis B
- Hepatitis C Other _____

Allergies: None Yes (indicate below)

- Asthma Hay Fever Penicillin
- Dairy Soy Wheat
- Peanuts Tree Nuts Poison Ivy
- Insect Stings Bee Stings Other _____

TB Mantoux Test: Date of Last Test: _____ Result: Positive Negative

To the best of my knowledge, there Is Is not a medical contraindication to administering acetaminophen (Tylenol® and Ibuprofen)

Describe any current physical, mental or psychological conditions requiring medication, treatment or special restrictions or conditions while at camp. _____

Describe any camp activities from which camper is exempted. _____

Describe any current treatments to be continued at camp including bronchial inhaler, bee sting kit, epi-pen or other health related device. _____

List all current medications to be administered at camp; prescribed or over-the-counter including name, dosage, route and frequency. _____

Describe any dietary restrictions. _____

List all known allergies. _____

Licensed Physician's Name (Please print or stamp below): _____ **Signature** _____

Address _____ Phone () _____

Date of completion of this form: _____ Completed by _____