

CAMP JOY MEDICAL HISTORY AND EMERGENCY FORM

THIS FORM MUST BE FILLED OUT BY PARENT OR GUARDIAN. THE INFORMATION IS REQUIRED BY N.Y. STATE LAW. YOUR CHILD WILL NOT BE ADMITTED INTO CAMP WITHOUT THIS FORM COMPLETELY FILLED OUT. IMMUNIZATION RECORD ARE TO BE ATTACH

NAME: _____ DATE OF BIRTH: _____ AGE: __ GENDER: M/F

ADDRESS: _____ ZIP: _____ PHONE: _____

PARENT/GUARDIAN NAME: _____ CELL PHONE: _____

IF NOT AVAILABLE IN EMERGENCY, NOTIFY: _____

EMERGENCY CONTACT'S RELATIONSHIP TO CAMPER: _____ PHONE: _____

PEDIATRICIAN: _____ PHONE: _____

DATE OF LAST VISIT: _____ IS CHILD ON MEDICATION? _____ FOR: _____

NAME OF MEDICATION(S): _____ DOSAGE: _____

TIME GIVEN: _____ (med release form require for administration during camp hours)

IS CHILD EPILEPTIC? _____ DATE OF LAST SEIZURE: _____ DIABETIC? _____

HEALTH HISTORY

IS YOUR CHILD'S HEALTH, IN GENERAL, GOOD? _____

ALLERGIES/SENSITIVITY

HAS CHILD HAD, OR IS CHILD SUBJECT TO:

RHEUMATIC FEVER _____

SINUS TROUBLE _____

EAR INFECTIONS _____

CONVULSIONS _____

DIABETES _____

FOODS _____

CHICKEN POX _____

OTHER _____

FAINING SPELLS _____

POISON IVY _____

INSECT STINGS _____

PENICILLIN _____

OTHER DRUGS _____

HAY FEVER _____

ASTHMA _____

OPERATIONS OR SERIOUR INJURIES: _____

_____ DATE: _____

RESTRICTIONS PLACED ON PROGRAM ACTIVITIES: _____

MODIFICATIONS/RESTRICTIONS/SUPPORTS IN PLACE DURING THE SCHOOL YEAR: _____

IMMUNIZATION RECORD:

A COPY OF CAMPER'S IMMUNIZATION RECORD MUST BE ATTACHED TO THIS FORM.

DIPHTHERIA/TETANUS TOXOID (4 DOSES)		DATE:	___	___	___	___	
ORAL POLIO VACCINE (3 OR MORE DOSES)		DATE:	___	___	___	___	
LIVE MEASLES VACCINE		DATE:	___	___	___	___	
LIVE RUBELLA VACCINE		DATE:	___	___	___	___	
LIVE MUMPS VACCINE		DATE:	___	___	___	___	
VARICELLA (CHICKEN POX)		DATE:	___	___	___	___	
HAEMOPHILUS INFLUENZA TYPE B		DATE:	___	___	___	___	
HEPATITUS B		DATE:	___	___	___	___	
Covid 19 Vaccination	Type _____	Dose 1	___	Dose 2	___	Booster	___

PARENT'S AUTHORIZATION

This health history is correct as far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted by me or by his/her doctor. If emergency care is needed by my son/daughter (print name: _____) while he/she is attending or being transported to or from Camp, I hereby give my permission to the authorized agents of New Rochelle Parks and Recreation to obtain a doctor to medically treat my son/daughter. I authorize transportation to, and treatment at, a hospital where required. I agree to assume all responsibility for all charges so incurred. I also agree to allow New Rochelle Parks and Recreation to release information to the hospital or to the doctor as may be required.

INSURANCE TYPE/NUMBER: _____

MEDICAID NUMBER: _____

SIGNATURE OF PARENT/GUARDIAN:

DATE: _____

CAMP HEALTH OFFICE USE ONLY

NOTES: _____

REVIEWED BY: _____ DATE: _____