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 ----------

FAINTING 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.

DIPTHERIA/TETANUS TOXOID (4 DOSES)	DATE:	___	___	___	___
ORAL POLIO VACCINE (3 OR MORE DOSES)	DATE:	___	___	___	
LIVE MEASLES VACCINE (1 DOSE)	DATE:	___			
LIVE RUBELLA VACCINE (1 DOSE)	DATE:	___			
LIVE MUMPS VACCINE (1 DOSE)	DATE:	___			
VARICELLA (CHICKEN POX)	DATE:	___			
HAEMOPHILUS INFLUENZA TYPE B	DATE:	___			
HEPATITUS B	DATE:	___			

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: _____