



**C.W. POST SUMMER DAY CAMP  
CAMPER HEALTH FORM 2009**

**THE FOLLOWING FORM MUST BE COMPLETED AND SIGNED BY THE CAMPERS PARENT OR GUARDIAN AS WELL AS SIGNED BY THE CAMPER'S PHYSICIAN. THIS INFORMATION PROVIDES CAMP HEALTH CARE PERSONNEL THE BACKGROUND NEEDED TO PROVIDE APPROPRIATE CARE TO EACH CAMPER. ANY CHANGES TO THE INFORMATION PROVIDED BELOW SHOULD BE GIVEN TO CAMP HEALTH PERSONNEL UPON PARTICIPANT'S ARRIVAL AT CAMP. PLEASE PROVIDE COMPLETE AND ACCURATE INFORMATION. HEALTH FORMS MUST BE CURRENT (WITHIN A YEAR) WHILE THE CAMPER IS AT CAMP OR YOUR CHILD WILL NOT BE ABLE TO ATTEND CAMP.**

**CAMPER INFORMATION**

NAME: \_\_\_\_\_  
Last First Middle

BIRTH DATE: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ AGE WHILE AT CAMP: \_\_\_\_\_ GENDER:  Female  Male

HOME ADDRESS: \_\_\_\_\_  
Street City State Zip

SOCIAL SECURITY NUMBER OF PARTICIPANT: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

CUSTODIAL PARENT / GUARDIAN NAME: \_\_\_\_\_  
Last First Middle

ADDRESS: \_\_\_\_\_  
Street City State Zip

DAYTIME PHONE: (\_\_\_\_) \_\_\_\_\_ EVENING PHONE: (\_\_\_\_) \_\_\_\_\_ CELL PHONE: (\_\_\_\_) \_\_\_\_\_

SECOND PARENT / GUARDIAN NAME: \_\_\_\_\_  
Last First Middle

ADDRESS: \_\_\_\_\_  
Street City State Zip

DAYTIME PHONE: (\_\_\_\_) \_\_\_\_\_ EVENING PHONE: (\_\_\_\_) \_\_\_\_\_ CELL PHONE: (\_\_\_\_) \_\_\_\_\_

IF PARENTS / GUARDIANS LISTED ABOVE ARE NOT AVAILABLE IN AN EMERGENCY, CONTACT:

\_\_\_\_\_

Last First

ADDRESS: \_\_\_\_\_  
Street City State Zip

DAYTIME PHONE: (\_\_\_\_) \_\_\_\_\_ EVENING PHONE: (\_\_\_\_) \_\_\_\_\_ CELL PHONE: (\_\_\_\_) \_\_\_\_\_

RELATIONSHIP \_\_\_\_\_

NAME OF CAMPER'S PHYSICIAN: \_\_\_\_\_ PHONE NUMBER: (\_\_\_\_) \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
Street City State Zip

IS THE CAMPER COVERED BY FAMILY MEDICAL / HOSPITAL INSURANCE? Yes  No

CARRIER OR PLAN NAME: \_\_\_\_\_ ID NUMBER: \_\_\_\_\_

**PHOTOCOPY OF FRONT AND BACK OF HEALTH INSURANCE CARD MUST BE ATTACHED TO THIS FORM.**

**CAMPER'S HEALTH HISTORY  
TO BE COMPLETED BY PHYSICIAN**

	<b>YES</b>	<b>NO</b>
1. RECENT INJURY, ILLNESS, OR INFECTIOUS DISEASE	<input type="checkbox"/>	<input type="checkbox"/>
2. CHRONIC OR RECURRING ILLNESS OR CONDITION	<input type="checkbox"/>	<input type="checkbox"/>
3. BEEN HOSPITALIZED	<input type="checkbox"/>	<input type="checkbox"/>
4. SURGERY	<input type="checkbox"/>	<input type="checkbox"/>
5. FREQUENT HEADACHES	<input type="checkbox"/>	<input type="checkbox"/>
6. HEAD INJURY	<input type="checkbox"/>	<input type="checkbox"/>
7. WEARS GLASSES, CONTACTS, OR PROTECTIVE EYEWEAR	<input type="checkbox"/>	<input type="checkbox"/>
8. FREQUENT EAR INFECTIONS	<input type="checkbox"/>	<input type="checkbox"/>
9. FAINTED DURING OR AFTER EXERCISE	<input type="checkbox"/>	<input type="checkbox"/>
10. SEIZURES	<input type="checkbox"/>	<input type="checkbox"/>
11. CHEST PAIN DURING OR AFTER EXERCISE	<input type="checkbox"/>	<input type="checkbox"/>
12. HIGH BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>
13. DIAGNOSED WITH A HEART MURMUR	<input type="checkbox"/>	<input type="checkbox"/>
14. BACK PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>
15. DIABETES	<input type="checkbox"/>	<input type="checkbox"/>
16. ASTHMA	<input type="checkbox"/>	<input type="checkbox"/>
17. DIARRHEA / CONSTIPATION	<input type="checkbox"/>	<input type="checkbox"/>
18. EATING DISORDER	<input type="checkbox"/>	<input type="checkbox"/>
19. IF FEMALE, HAS THE CAMPER MENSTRUATED	<input type="checkbox"/>	<input type="checkbox"/>
20. EMOTIONAL DIFFICULTIES FOR WHICH PROFESSIONAL HELP WAS SOUGHT	<input type="checkbox"/>	<input type="checkbox"/>

**\*PLEASE EXPLAIN ANY "YES" ANSWERS, NOTING THE NUMBER ON A SEPARATE SHEET OF PAPER.**

**PLEASE MARK IF CAMPER HAS HAD:**

- MEASLES
- CHICKEN POX    IMMUNIZATION \_\_\_\_\_
- GERMAN MEASLES
- MUMPS
- HEPATITIS
- TB TEST RESULTS AND DATE: \_\_\_\_\_

**DATE OF LAST IMMUNIZATION:**

- \_\_\_/\_\_\_/\_\_\_    DTP
- \_\_\_/\_\_\_/\_\_\_    TETANUS / DIPHTHERIA
- \_\_\_/\_\_\_/\_\_\_    TETANUS
- \_\_\_/\_\_\_/\_\_\_    POLIO
- \_\_\_/\_\_\_/\_\_\_    MEASLES
- \_\_\_/\_\_\_/\_\_\_    RUBELLA
- \_\_\_/\_\_\_/\_\_\_    HEPATITIS B
- \_\_\_/\_\_\_/\_\_\_    TB
- \_\_\_/\_\_\_/\_\_\_    HAEMOPHILUS INFLUENZA B

**PLEASE ANSWER THE FOLLOWING QUESTIONS AND ATTACH ADDITIONAL PAGES IF NECESSARY**

PLEASE PROVIDE INFORMATION REGARDING PARTICIPANT'S PHYSICAL, EMOTIONAL, OR MENTAL HEALTH WHICH C.W. POST SUMMER DAY CAMP HEALTH STAFF SHOULD BE AWARE OF \_\_\_\_\_

LIST ALL MEDICATION(S) AND USE. MEDICATIONS BROUGHT TO CAMP MUST BE IN THE ORIGINAL PACKAGING THAT IDENTIFIES THE PRESCRIBING PHYSICIAN, THE NAME OF THE MEDICATION, THE DOSAGE, AND THE FREQUENCY OF ADMINISTRATION (attach an additional page if necessary).

\_\_\_\_\_

DESCRIBE AND EXPLAIN ANY ACTIVITY RESTRICTIONS: \_\_\_\_\_

DESCRIBE AND EXPLAIN ANY DIETARY RESTRICTIONS: \_\_\_\_\_

LIST ALL KNOWN ALLERGIES. DESCRIBE REACTION AND MANAGEMENT OF THE REACTION (attach another page if necessary)

\_\_\_\_\_

I EXAMINED THIS INDIVIDUAL ON \_\_\_\_\_

HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ B.P. \_\_\_\_\_ INDIVIDUAL CAN PARTICIPATE IN ALL CAMP ACTIVITIES \_\_\_\_ YES \_\_\_\_ NO

**\*IF ANSWER IS NO PLEASE INDICATE EXPLANATION ON A SEPARATE PIECE OF PAPER**

PHYSICIAN'S NAME _____	ADDRESS & OFFICE STAMP _____
SIGNATURE OF PHYSICIAN _____	DATE _____

THE HEALTH HISTORY DESCRIBED ABOVE IS CORRECT, AND THE CAMPER DESCRIBED HAS PERMISSION TO ENGAGE IN ALL CAMP ACTIVITIES EXCEPT AS NOTED.

I HEREBY GIVE PERMISSION TO THE CAMP, CAMP MEDICAL STAFF, AND CAMP STAFF TO PROVIDE ROUTINE HEALTH CARE, ADMINISTER PRESCRIBED MEDICATIONS, AND SEEK EMERGENCY MEDICAL TREATMENT INCLUDING X-RAYS AND ROUTINE TESTS.

I HEREBY GIVE C.W. POST SUMMER DAY CAMP PERMISSION TO TAKE MY CHILD TO ANY HOSPITAL FACILITY OR OUTSIDE DOCTOR WHEN DEEMED NECESSARY. FURTHERMORE, I HEREBY GIVE PERMISSION TO SUCH HOSPITAL OR OUTSIDE DOCTOR TO AUTHORIZE X-RAYS AND EMERGENCY TREATMENT IF DEEMED NECESSARY. I UNDERSTAND THAT ALL MEDICAL BILLS FOR SERVICES RENDERED BY ANYONE OTHER THAN THE CAMP'S MEDICAL STAFF ARE MY RESPONSIBILITY. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION OR RECORDS RELATED TO THE TREATMENT, REFERRAL, BILLING, OR INSURANCE PURPOSES RELATED TO MY CHILD.

**SIGNATURE OF PARENT OR GUARDIAN: \_\_\_\_\_ DATE: \_\_\_\_\_**