

Mohawk Day Camp ☀ Mohawk Country Home School

Div. Mohawk-White Plains, Inc.
Old Tarrytown Road, White Plains, NY 10603
www.campmohawk.com ☀ www.mohawkhomeschool.com ☀ info@campmohawk.com
Phone: 914-949-2635 ☀ Fax: 914-949-7345

PARENT AND/OR GUARDIAN MUST COMPLETE THIS SIDE OF FORM
YOUR PHYSICIAN MUST COMPLETE THE BACK & ATTACH CURRENT VACCINATION RECORD

Child's Name: *(please print)*: _____ Date of Birth: _____ Weight: _____

Significant Health History (i.e., diabetes, seizures, heart disease, etc.): _____

Allergies (foods, drugs, plants, insects, etc.): _____

Does your child require an epi-pen: Yes* _____ No _____

**If "yes," complete "Epi-pen Information and Agreement" form.*

Emotional concerns (explain): _____

Operations or serious injuries (explain with dates): _____

Disability or chronic or recurring illness: _____

Any specific activities to be limited by physician's advice: Yes* _____ No _____ **If yes, attach letter of explanation.*

Dietary modifications (if so, attach letter of explanation): _____

Current medication(s)*: _____

**Use enclosed "Parent Medication Consent Form" if your child requires medication while on our site.*

Name of dentist/orthodontist: _____ Phone: _____

Tylenol, Motrin or Benadryl may be dispensed by designated personnel, as needed according to standard dosage. If you DO NOT wish to authorize Tylenol, Motrin, and/or Benadryl, notify us in writing in the space below:

In the event of a nuclear accident or emergency where radioactive iodine released into the air may likely affect your child on site, we plan to dispense potassium iodide (KI) pills. This would be done upon the recommendation by federal, state or local authorities. If you DO NOT wish to authorize our dispensing potassium iodide under these circumstances, notify us in writing in the space below:

If we need to reach you or a representative for your child,
we will use the contacts you have provided on your child's registration form.

Parent Signature _____

Date: _____

TO BE COMPLETED BY PHYSICIAN

Child's Name: *(Please Print)* _____ Date Examined _____

Please attach immunization records here & complete rest of the form

Significant medical history (including seizures, surgeries, loss of consciousness, etc.): _____

Allergies (foods, drugs, plants, insects, etc.): _____

Epi-Pen needed? Yes No (If yes, please sign the Epi-Pen Information and Agreement)

Emotional health concern (ADD, ADHD, phobias, etc.): _____

Child is under the care of a physician for the following condition (physical and/or behavioral): _____

Current treatment (include current medication): _____

Any prescribed medication to be administered during the day? Yes No (If yes, please sign the Parent Medication Consent Form)

Any physical restrictions (If so, describe): _____

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|---|---|

MD Name *(Please Print!)*: _____

Phone: _____

MD Signature: _____

Date: _____