



Country Day Camp

# Camper Medical Report Summer 2008

PO Box 6623  
Freehold, NJ 07728  
732-308-0405  
Fax 732-780-4726  
www.rollinghillsdaycamp.com

**PLEASE RETURN THIS FORM TO THE CAMP OFFICE**

Camper's Last Name	Camper's First Name	Camper's Date Of Birth
Home Address	City	Camper's Grade (as of Sept 2008)

## CONTACT INFORMATION IN CASE OF AN EMERGENCY

Mother's Name	Home Phone #	Work Phone #	Cell Phone #	
Father's Name	Home Phone #	Work Phone #	Cell Phone #	
Other (if applicable)	Home Phone #	Work Phone #	Cell Phone #	Relationship To Camper

## ALLERGIES

The following information must be filled in by the parent/guardian. The intent of this information is to provide camp health personnel the background to provide appropriate care. Provide complete information so that the camp can be aware of your needs; withholding information from the camp will compromise the care we are able to give to your child. Please keep a copy of the completed form for your records. Any changes to this form should be provided to the camp health personnel immediately.

MEDICATION ALLERGIES:	Please describe reaction and management to the reaction.
FOOD ALLERGIES:	Has your child ever had any adverse reactions to this food? <input type="checkbox"/> No <input type="checkbox"/> Yes (please describe)
OTHER ALLERGIES:	

## MEDICATIONS BEING TAKEN

Please list ALL medications (including Over-The-Counter) taken routinely. Send enough medication to last the entire session at camp. Keep all medication in the original packaging/bottle that identifies the prescribing physician (if a prescription medication,) the name of the medication, the dosage, and the frequency. Please label all medication with the camper's name and group. It will be stored and dispensed at the Nurse's Office.

<input type="checkbox"/> My child takes NO MEDICATION ON A ROUTINE BASIS.	
<input type="checkbox"/> My child TAKES MEDICATION as follows:	
<input type="checkbox"/> My child takes prescription behavioral medication (please describe) _____	
Medication # 1	Medication # 2
Dosage:	Dosage:
Taken at this time:	Taken at this time:
Reason for taking medication:	Reason for taking medication:
Prescribing Doctor (if applicable):	Prescribing Doctor (if applicable):

*Attach an additional sheet of paper if necessary.*

-over-

\_\_\_\_\_ is able to participate in all camp activities except the following:  
 (camper's name)

Restrictions from camp activities:
Restrictions from food:
Is your child currently receiving any professional counseling or therapy? <input type="checkbox"/> No <input type="checkbox"/> Yes (please describe)
Please use this space to provide additional information about your child's behavior, physical, emotional or mental health which we should be aware of:
The Camp Nurse has my permission to administer the following over-the-counter medications according to the label instructions, at their discretion: Throat Lozenges · Pepto-Bismol · Tylenol · Advil · Sudafed · Benadryl (This list is not all inclusive.)

**PARENT AUTHORIZATION**

This health history is correct and complete. The camper described in this form has permission to engage in all camp activities except as noted above. I hereby grant permission to the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment, if necessary. In the event I cannot be reached in an emergency, I hereby grant permission to the camp to secure and administer treatment. The completed form may be photocopied for trips out of camp.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

**PHYSICAL EXAMINATION** (To be filled out by licensed physician)

I examined this individual on \_\_\_\_\_. In my opinion, the above camper  is  is not able to participate in all camp programs.  
 (date)

Height
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Weight
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BP
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Glasses:  
 Yes  No

Contact Lenses:  
 Yes  No

Vaccine:	Mon/YR	Mon/YR	Mon/YR	Mon/YR	Mon/YR	Mon/YR
DPT						
TD (Tetanus/diphtheria)						
Tetanus						
Polio						
MMR						
or Measles						
or Mumps						
or Rubella						
Haemophilus influenza B						
Hepatitis B						
Varcella (chicken pox)						
TB / MANTOUX TEST _____ positive _____ negative						

Which of the following has the participant had?  
 Measles                       Hepatitis A                       Hepatitis C                       Mumps  
 German Measles                       Hepatitis B                       Chicken Pox

Name of Physician:	Phone:
Signature of Physician:	Date:
Name of Dentist/Orthodontist:	Phone:

