

# 2017 LAGRANGE DAY CAMP HEALTH FORM

**LaGrange Parks & Recreation**  
120 Stringham Road  
LaGrangeville, NY 12540  
845-452-1972

(Please check) Session(s) Child is Attending  
Session 1 \_\_\_\_\_  
Session 2 \_\_\_\_\_  
Session 3 \_\_\_\_\_

**Must be completed by parent or guardian in order to attend camp. Immunization records required.**

**All forms including camper information form must be filled out completely in order to hold camp spot. Faxes WILL NOT be accepted.**

_____	_____	____/____/____	_____	_____
Camper Last Name	Camper First Name	Date of Birth	Sex	Age
Parent/Guardian #1 First & Last Name _____		Parent/Guardian #2 First & Last Name _____		
Parent/Guardian #1 Phone Numbers: home, cell, work _____		Parent/Guardian #2 Phone Numbers: home, cell, work _____		
Parent/Guardian #1 Business Name, Address, Phone # _____		Parent/Guardian #2 Business Name, Address, Phone # _____		

**If parent/guardian listed above is not available in an emergency, notify: (must be available to pick up child from camp in 15 minutes)**

_____	_____	_____	_____
Name	Relationship	Home Phone	Work Phone
Address _____			Cell Phone _____
_____	_____	_____	_____
Name	Relationship	Home Phone	Work Phone
Address _____			Cell Phone _____

**If an emergency arises and neither parent nor alternative persons can be reached at once, I authorize LaGrange Day Camp to take all measures that they consider necessary for the protection of the health and safety of my child, including hospitalization.**

**Health History** (check, giving approximate dates where indicated):

<b>Conditions:</b>	<b>Allergies:</b>	<b>Diseases:</b>	<b>Dates:</b>
<input type="checkbox"/> Frequent ear infections	<input type="checkbox"/> Asthma	<input type="checkbox"/> Mononucleosis:	_____
<input type="checkbox"/> Heart defect/disease	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Chicken Pox:	_____
<input type="checkbox"/> Convulsions	<input type="checkbox"/> Poison Ivy	<input type="checkbox"/> Measles:	_____
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Insect Sting	<input type="checkbox"/> German Measles:	_____
<input type="checkbox"/> Bleeding/Clotting Disorder	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Mumps:	_____

**Other diseases or details of above:** \_\_\_\_\_

Any specific activities to be encouraged or limited by physician's advice:

Can this child go underwater? \_\_\_\_\_ Dietary Modifications: \_\_\_\_\_

Current Medications (send with doctor's note and instructions): \_\_\_\_\_

(For Females): Has this person menstruated? \_\_\_\_\_ If not, has she been told about it? \_\_\_\_\_

Name of Dentist/Orthodontist \_\_\_\_\_ Phone \_\_\_\_\_

Name of Family Physician \_\_\_\_\_ Phone \_\_\_\_\_

Date of Last Physical Examination \_\_\_\_\_

Family medical/hospital insurance carrier \_\_\_\_\_ Policy or Group # \_\_\_\_\_

**OVER**, signature required

**\*\* Please do not place grouping requests on this form\*\***

**ALL SECTIONS MUST BE COMPLETED AND SIGNED**

**PHOTO RELEASE:**

I hereby grant the Town of LaGrange permission to use my child's photograph, video picture and/or other digital reproduction of him/her or of his/her physical likeness for publication and/or promotional purposes of LaGrange Parks & Recreation activities.

\_\_\_\_\_ Accept \_\_\_\_\_ Decline

**Parent/Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**PERMISSION/ AGREE TO HOLD HARMLESS:**

As the participant signed below, knowing fully that the Town of LaGrange Parks and Recreation Department provides the program activity, and or special event and all aspects associated with these being; Facility(s), Instructor(s), Equipment and Supervision, I hereby: 1. Agree to furnish my own insurance in case of injury, 2. Assume all risks and responsibilities of possible injury involved with participating in this program, activity, and or special event, 3. Testify that I am in sound health and capable of participating in the registered program, 4. Further agree to indemnify and hold harmless the Town of LaGrange, Parks & Recreation Department or employees, to include volunteers, from liability resulting from my participation in this program, activity or special event.

**Parent/Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**MEDICAL RELEASE/AUTHORIZATION:**

In case of emergency, I hereby give permission to the medical personnel selected by the camp, in my absence, to act as my agent in securing proper medical treatment for my child as named above, including hospitalization, routine tests, X-rays and other medical treatment. Every possible effort will be made to contact parents in the event of an emergency.

**Parent/Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

I give the Town of LaGrange and Recreation Staff permission to apply to my child the following topical ointments and treatments if needed while participating in our program:

Neosporin or similar ointment:	YES _____	NO _____
Alcohol Wipes:	YES _____	NO _____
Deet-Free bug spray:	YES _____	NO _____
Sunscreen:	YES _____	NO _____
Sting Stop:	YES _____	NO _____

**Parent/Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_





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120 Stringham Road

LaGrangeville, NY 12540

845-452-1972 www.lagrangeny.gov

**Changing Lives...Inspiring Play...Fostering Teamwork!**

### CAMPER BACKGROUND FORM

Thorough information on this form will help us to serve your child better!

Use the back for any information that does not fit on the front.

Session: 1 \_\_\_\_\_ 2 \_\_\_\_\_ 3 \_\_\_\_\_

\_\_\_\_\_ Camper's Last Name                      Camper's First Name                      Nickname if any

Grade in Fall \_\_\_\_\_ Birthdate \_\_\_\_\_ School \_\_\_\_\_

Please list the members of your child's household and the relationship to them:

Member	Relationship	Member	Relationship

Has your child been to day camp before? \_\_\_\_\_ Where \_\_\_\_\_

Explain any significant losses or changes in the household or in you child's circle of friends, classmates and extended family:

What concerns, if any, do you have about sending your child to camp \_\_\_\_\_

Describe any habits, characteristics or phobias we should be aware of to help us better care for your child:

Explain any fears you or your child has about water: \_\_\_\_\_

List any food allergies your child has: \_\_\_\_\_

Please explain any special needs your child may have so we can be prepared to make their stay as comfortable as possible:

Does your child receive any special services during the school year?     yes     no    If yes, please explain \_\_\_\_\_

As per amendments made in 2016 to the NYS DOH Children's Camp Code camps have been advised to "identify camper disability information (developmental and/or physical disabilities) during the camp's enrollment process..." In addition, camps are advised to determine if such children have an "individual treatment, care or behavioral plan that address a camper's unique physical, medical, behavioral, and/or social needs." Such a plan is not necessary, but if one exists the details should be shared with the camp. With regards to this now Code amendments we ask:

Does this child have a severe chronic disability attributable to (quoted from the Code) "mental retardation, cerebral palsy, epilepsy, autism or neurological impairment" as determined by a qualified practitioner with a relevant Master's Degree or Doctorate in Psychology?     yes     no

If yes, does your child have an individual treatment, care or behavioral plan?     yes     no