

# 2015 DAY CAMP HEALTH FORM

**LaGrange Recreation**  
120 Stringham Road  
LaGrangeville, NY 12540

Phone 452-1972

(Please check) Session(s) Child is Attending

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

***Must be completed to attend camp. Immunization records required.***

Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_

Parents or Guardians \_\_\_\_\_ Phone: \_\_\_\_\_

Mom's Cell: \_\_\_\_\_ Dad's Cell: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Home Address \_\_\_\_\_

Street & Number City State Zip Code

Father's Business Address \_\_\_\_\_ Phone \_\_\_\_\_

Mother's Business Address \_\_\_\_\_ Phone \_\_\_\_\_

If not available in an emergency, notify:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Street & Number City State Zip Code

Health History: (Check & give approx. dates)

DIAGNOSIS

Frequent Ear Infections \_\_\_\_\_  
Heart Defect/Disease \_\_\_\_\_  
Convulsions \_\_\_\_\_  
Diabetes \_\_\_\_\_  
Bleeding/Clotting Disorders \_\_\_\_\_  
Hypertension \_\_\_\_\_  
Mononucleosis \_\_\_\_\_  
Asthma \_\_\_\_\_  
Hay Fever \_\_\_\_\_  
Ivy Poisoning \_\_\_\_\_  
Insect Stings \_\_\_\_\_  
Penicillin Sensitivity \_\_\_\_\_  
Other Drugs \_\_\_\_\_

ADHD \_\_\_\_\_  
Autism \_\_\_\_\_  
PDD \_\_\_\_\_  
Speech/Hearing Impairment \_\_\_\_\_  
other concerns \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Physical Disability or recurring illness \_\_\_\_\_

Learning Disability \_\_\_\_\_

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

Can this child go underwater? \_\_\_\_\_

Dietary Modifications: \_\_\_\_\_

Current Medications (send with 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 \_\_\_\_\_

Do you carry medical/hospital insurance? \_\_\_\_\_ Policy or Group # \_\_\_\_\_

**OVER,** signature required

Please don't place grouping requests on this form.

A Doctor's signature is not required except when your child needs to receive medication during camp. If your physician directs that a medication must be given to your child during camp, it must be self-administered and witnessed by the Camp Health Director, provided your Doctor sends camp staff a written statement with: name of camper; diagnosis; name of medication, dosage, and time to be given; any special instructions. All medication must be brought to camp by the parent. Do not send children on the bus with medication.

**PARENT'S SIGNATURE IS REQUIRED**

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted.  
 Emergency Authorization: I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests and treatment for me/or my child and in the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injections and/or anesthesia and/or surgery for me/my child as named above. This form may be copied for use out of camp.

 **Signature of parent or guardian** \_\_\_\_\_ **Date** \_\_\_\_\_

**IMMUNIZATION RECORDS ARE REQUIRED**

Either complete the form below with specific dates or attach a Physician's record.

VACCINES	Date of Basic Immunization	Date of Last Booster
Diphtheria Pertussis (Whooping Cough) DPT* Tetanus or	1 2 3	1 2
Tetanus TD* Diphtheria or		
Tetanus		
Oral Polio (Sabin)* TOPV		
Injectable Polio (Salk)		
Measles (hard measles, red measles, rubella)		
Haemophilus Influenza Type B		
Hepatitis B		
Varicella (Chicken Pox)		
Other		
Tuberculin test given  _____ Most recent		