

Gate Hill Day Camp

P.O. Box 592 - Stony Point, NY – 10980
(845) 947-3223/(845) 942-0958 Fax

Please return by May 16th

Camper Medical

Camper: _____ Phone: _____
Address: _____
Birth date: _____ Age: _____ Months: _____ Sex: M / F
Mother's Name: _____ Business Phone: _____
Father's Name: _____ Business Phone: _____

If the nurse needs to reach you or a representative for your child, please list (in order of preference) the persons/numbers we should call:

1. _____ 2. _____ 3. _____
Home # _____ Home # _____ Home # _____
Work/Cell # _____ Work/Cell # _____ Work/Cell # _____

HEALTH HISTORY:

Significant Family History: _____
Significant Past Illness, Injuries, Operations: _____
Current Health Problems: _____
Chronic or Recurring Illness: _____
Other Diseases: _____
Allergies: Hay Fever _____ Shell Fish _____ Insect Stings _____ Peanuts _____
Latex _____ Asthma _____ Poison Ivy, etc. _____ Other _____
Any specific activities to be encouraged? _____
Any specific activities to be discouraged? _____

Important: Please notify the camp if this camper is exposed to any communicable disease during the three weeks prior to camp.

Camp Nurse may administer the following: (Parent MUST initial their choices)

Acetaminophen (Tylenol) _____ Ibuprofen (Advil) _____ Benadryl _____

Medications Being Taken

Please list all medications (including over the counter or non prescription drugs) taken routinely. **When sending medication to camp, keep it in the original prescription bottle/packaging that identifies the prescribing physician (if prescription drug), the name of the medication, the dosage, and the frequency of administration.**

This person takes NO medications on a routine basis. OR		This person takes medications as follows:	
Med # 1 _____	Dosage _____	Specific times taken each day _____	
Reason for taking _____			
Med # 2 _____	Dosage _____	Specific times taken each day _____	
Reason for taking _____			
Med # 3 _____	Dosage _____	Specific times taken each day _____	
Reason for taking _____			

Please be sure to sign the parent authorization on the other side of this form.

Parents Authorization:

This health history is correct, so far as I know. We have read the camp brochure and we give permission for our child to participate in all activities, except as noted by the examining physician and me. In the event I cannot be reached in an EMERGENCY, I hereby give permission, so the physician selected by the camp director, to hospitalize and secure proper treatment and to order injection, anesthesia, or surgery for my child as named above. In addition, I hereby give permission to the camp nurse to administer the medications I initialed on the other side of this form.

No camper may attend Gate Hill without a physician signed medical form indicating up-to-date immunization. (This is a Rockland County Board of Health Mandate.)

Signature: _____

Date: _____

MEDICAL EXAMINATION to be filled out by a licensed physician. This examination is to be performed within 12 months of arrival at camp. Examination is for determining fitness to engage in strenuous activity.

CODE: S = Satisfactory X = Not Satisfactory (explain) O = Not Examined

Height: _____ Weight: _____ BP: _____ HG Test: _____ Urinalysis: _____

Eyes: _____ Extremities: _____ Glasses: _____
Posture: _____ Ears: _____ Skin: _____
Nose: _____ Throat: _____ Teeth: _____
Heart: _____ Lungs: _____ Abdomen: _____
Hernia: _____ Allergy: _____
General Appraisal: _____

Immunization History

Polio OPV (satin): _____ Booster: _____ TB: _____ Tetanus Booster: _____
Measles: _____ 2nd Measles: _____ German Measles: _____ MMR: _____
DTP Series: _____ Booster: _____ Mumps Vaccine (live): _____ Hepatitis B: _____
Varicella (chicken pox): _____ Haemophilus influenza type B: _____

Recommendations and restrictions while at camp:

Special Diet: _____
No participation in: _____
Limited Participation in: _____
Requires: _____
Full Participation in: _____

I have examined the person herein described and have reviewed his/her health history. It is my opinion that he/she is able to engage in camp activities, except as noted above. I also give my permission for the camp nurse to administer the medications indicated by the parents on the other side of this form.

Examining Physician: _____ **Telephone:** _____

Address: _____ **Date:** _____

