Norwich Summer Camp Health Form

Camp Name/Date(s):_____

The health form is kept confidential and used by our health services staff (or emergency medical personnel). Every camper needs a completed health form to participate in any summer camp programs. Please fill out this form as completely as possible. Thank you!

SECTION I – BASIC CONTACT INFORMATION Camper Name_____

Birth date_____/_____/_____ Age _____ Gender Male

Home Address_____

STREET CITY STATE ZIP

Home Phone_____

Parent/Guardian #1
Name_____
Relationship:_____ Day Phone_____ Night Phone_____ Day Phone is Home Work Cell Night Phone is Home Work Cell Parent/Guardian #2
Name_____
Relationship:_____ Day Phone_____ Night Phone_____ Day Phone is Home Work Cell Night Phone is Home Work Cell Additional Emergency Contact_____ Relationship_____ (In case we can't reach YOU) Day Phone_____ Night Phone_____ Day Phone is Home Work Cell Night Phone is Home Work Cell

Family Physician Name_____ Phone_____

Dentist/Orthodontist Name_____ Phone_____

SECTION II – INSURANCE INFORMATION Is the camper covered by family medical/hospital insurance? Yes No If yes, indicate Insurance Carrier_____ Group #_____ Policy #_____ Policy Holder's Name_____ Relationship to participant_____

MEDICATIONS Will camper be taking medications while at camp? Yes No

(Medications include prescription, over-the-counter, vitamins, inhalers, etc.)

If camper will be taking medications while at camp, we need to secure your consent for medication distribution and for the use of medical devices. The medication can be self-administered (if over 18) or administered by qualified staff. Please list all (prescription and non-prescription). Include the medication name, prescribing physician, physicians' phone number, and the dosage instructions. Use an additional sheet if needed. When you check-in at camp, please provide all medications (in their original packaging that identifies the prescribing physician (if prescription drug), the name of the medication, the dosage, and frequency of administration.

_____ I want the medication or medical devices self-administered. (Age 18 and above only.) _____ I want the medication or medical device administered by the Health Services Staff. However, a limited amount of medication for life threatening conditions should be carried by my son/daughter/ward. (i.e. bee sting kits, inhalers)

Medication_____ Dosage_____ Take at what times_____ Reason for Taking_____
Prescribing Physician_____
Phone_____

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Prescribing Physician_____
Phone_____

ALLERGIES Camper does not have any Allergies _____

Camper is allergic to: ___Hay Fever ___Poison Ivy/Oak ___Insect Stings ___ Food ___Penicillin ___Other Drugs ____Other (List allergy. Describe reaction and treatment)
_____
_____
_____

IMMUNIZATIONS Please record the month and year of immunizations. If you do not know the dates or whether camper has had certain immunizations, simply leave blank.

DPT (Diphtheria, Pertussis, Tetanus) _____ HIB (Haemophilus Influenza B) _____

Tetanus Booster _____ Tuberculin _____ Polio _____ Varicella (Chicken Pox). _____ MMR (Measles, Mumps, Rubella _____ Hepatitis B _____

HEALTH HISTORY Please know that we value your privacy. Health History information is available only to the camp health staff. The more information you provide, the better we can do our job. Thanks!

Has the camper have a history of or is prone to any of the following (Please circle all that apply).

1. Recent injury, illness or infectious disease 2. Chronic or recurring illness 3. Asthma

4. Homesickness 5. Frequent Ear Infections 6. Seizure Disorder or Convulsions

7. Dizziness during or after exercise 8. Chest pain during or after exercise 9. Heart Defect/Disease

10. Hypertension 11. Bleeding/Clotting Disorders 12. Diabetes

13. Mononucleosis (in last 12 months) 14. Chicken Pox 15. Measles 16. German Measles

17. Mumps 18. Tuberculosis 19. Hepatitis 20. Joint problems (knees, ankles) 21. Fractures

22. Frequent Headaches 23. Head Injury 24. Eating Disorder 25. Diarrhea or constipation

26. Frequent Stomachaches 27.Wears glasses or contacts 28. Been Hospitalized 29. Wears Medic Alert ID

Please list the number and provide explanation for any checked items

_____

_____

_____

Date of Last Physical Exam (Recommended within 24 months of camp)_____

Physical Activities to be limited or restricted while at camp:

_____

_____

AUTHORIZATION My child has permission to engage in all prescribed camp activities except as noted. The information provided on this form is accurate to the best of my knowledge. I have indicated any special health conditions, including required medication and activity limitations which should be known to the camp staff and medical personnel. I am aware of and accept the risk inherent in the program activity. I give consent in advance for medical treatment at an appropriate facility in case of illness or injury.

Signature of Parent or Guardian X_____ Date_____