

WONDERLAND CAMPER HEALTH INFORMATION FORM

(Note: This side to be completed by parent, **notarized** and returned to SYJCC office 1 month before the start of camp.)

Camper's Last Name _____ First Name _____ Sex _____ Date of Birth _____ Age _____ Grade _____
(as of Sept.)

Address _____ Town//Zip _____ Home Phone _____

Parent 1/Guardian: _____ Work Number: _____ Cell Phone: _____

Parent 2/Guardian: _____ Work Number: _____ Cell Phone: _____

Email Address: _____

Emergency Name #1 _____ Emergency Phone _____

Emergency Name # 2 _____ Emergency Phone _____

Family Physician, Name _____ Telephone Number _____

HEALTH HISTORY: (Check - give approximate dates)

____ Frequent Colds ____ Abscessed Ears ____ Fainting ____ Stomach Upsets ____ Athlete's Foot ____ Sinusitis
____ T.B. ____ Bronchitis ____ Motion Sickness ____ Convulsions ____ Whooping Cough ____ Polio ____ Poison Ivy
____ Rheumatic Fever ____ Heart Trouble ____ Diabetes ____ Poison Oak/Sumac

Has daughter menstruated? _____ Has she been told about it? _____

Operations, Serious illnesses or injury, explain. _____

Any specific activities to be encouraged _____

Any specific activities to be restricted _____

MEDICATIONS BEING TAKEN

Please list ALL medications (including over-the-counter or non-prescription drugs) taken routinely. If camper needs medication during camp hours, keep it in the original packaging/bottle that identifies the prescribing physician, the name of the medication, the dosage, and the frequency of administration. A doctor's note and Parent's note will also be required.

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 _____

Attach additional pages for more medications.

Identify any medications taken during the school year that participant does/may not take during this summer: _____

IMPORTANT: Please notify the camp if your child was exposed to any communicable diseases during the **3 weeks prior** to camp attendance.

AUTHORIZATION FOR EMERGENCY MEDICAL SURGICAL TREATMENT

NOTE: It is the firm hope that the authorization granted on this form will never have to be used. However, for the safety of your child, sound medical practice calls for such authorization. In emergency situations where for some reason, the parent cannot be contacted immediately, this form may be extremely important. Doctors and hospitals refuse to give any treatment, regardless of how minor, unless they have a notarized authorization from a parent.

THE AUTHORIZATION GRANTED BY THIS FORM WILL BE USED ONLY WHEN ABSOLUTELY NECESSARY AND ONLY AFTER EVERY ATTEMPT HAS BEEN MADE TO CONTACT A PARENT.

I understand that in the event I cannot be reached, I hereby give permission to the physician or hospital selected by the SYJCC camp administration to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child, as named above.

Signature of Parent/Guardian (Must sign in front of Notary)

Date

Notary: _____

Date

(Please have your physician fill out and sign the reverse side of this form before returning it to the SYJCC Office. Thank you.)

PHYSICAL EXAMINATION

Camper's Name _____ **WONDERLAND CAMP PROGRAM**

Date of Examination _____ (To be completed by a Licensed Physician)

Code: _____ Satisfactory: _____ Not Satisfactory (please explain) _____

Hgt. _____ Blood Pressure _____ Eyes _____ Glasses? _____ Wgt. _____

Hgb. Test Done: _____ Urine Analysis Test Done? _____ Ears _____ Extremities _____

Nose _____ Posture (spine) _____ Throat _____ Skin _____ Heart _____

Genitalia _____ General Appraisal: _____

Lungs _____ Hernia _____ Abdomen _____ Menstrual History _____

Recommendations and/or restrictions (diet, medicine, swimming, diving, etc.) _____

ALLERGIES List all known. Describe reaction and management of the reaction.

Medication Allergies (list)

Food Allergies (list)

Other Allergies (list) - include insect stings, hay fever, asthma, animal dander, etc.

IMMUNIZATIONS: PLEASE ENTER DATES (State law requires dates to be entered)

Which of the following has the participant had?

Please give all dates of immunization for:

Vaccine: Dates: Mo/Yr Mo/Yr Mo/Yr Mo/Yr Mo/Yr Mo/Yr

Measles

DTP

Chicken pox

TD (tetanus/diphtheria)

German measles

Tetanus

Mumps

Polio

Hepatitis A

MMR

Hepatitis B

Or Measles

Hepatitis C

Or Mumps

Or Rubella

TB Mantoux test

Haemophilus influenza B

Date of last test _____

Hepatitis B

Result: Positive Negative

Varicella (chicken pox)

Signature of Examining Physician

Telephone Number

Date of Examination

Physician's Stamp

(Reverse side to be completed by Parent)