

Adult or Child

Participant Name _____ Birth date ___/___/___ Age at camp ___

Last

First

Middle



NH law REQUIRES a physical exam WITHIN 2 YEARS of camp arrival. Complete all parent sections of this 2008 form, which is REQUIRED at check-in and must be completed for all adult & child campers, volunteers, and staff attending camp events. "Medical Practitioner's Section" MUST be completed & signed if one is not on file at camp for the prior year.

Custodial Parent/Guardian (for child participant) _____

Home Phone (____) ____ - ____ Work phone (____) ____ - ____ Cell phone (____) ____ - ____

Address _____ Street City or Town State Zip Code

OTHER Legal Parent / Guardian _____

Home Phone (____) ____ - ____ Work phone (____) ____ - ____ Cell phone (____) ____ - ____

Address _____ Street City or Town State Zip Code

EMERGENCY CONTACT (someone not listed above who can contact parent/guardian)

Name _____ Relationship _____

Home Phone (____) ____ - ____ Work phone (____) ____ - ____ Cell phone (____) ____ - ____

HEALTH INSURANCE: Is participant covered by health ins.? Yes No

If yes, Insurance carrier: _____

Policy number _____ Policy holder _____

Date of birth of policy holder _____ Relationship to participant _____

Phone and Mailing address of insurance company _____

Camper will be covered under their own policy while at camp.

ALLERGIES Please list all known allergies, type of reaction, and required treatment:

- Poison Ivy/oak _____
Insect Bites/stings _____
Foods _____
Medications _____
Other allergies _____

VACCINATION and IMMUNIZATION RECORD: Please list dates of administration and attach documentation.

(1)____(2)____ Measles, Mumps, Rubella (MMR) (1)____(2)____(3)____ Polio (3 doses or more, last dose after 4th birthday)
(MMR dose 2 required grades 7-12) (1)____(2)____(3)____ Hepatitis B (if born on/since Jan. 1, 1993)
(Adults)____ Tetanus (DT) within past 10 years (Children) (1)____(2)____(3)____ DT aP (4 doses or more, 4th dose between 4th & 7th birthday)
(boosters may be required for adult) _____ Varicella (Chicken Pox) (not mandatory)

HEALTH CONDITIONS and RESTRICTIONS

Please indicate if participant has any of the following physical, dietary, or emotional conditions. What is the best way to handle these conditions? Are there any that could/would restrict activity while at camp?

- asthma chronic illness fainting sleep walking seizures
back pain dental wear hearing impaired menstrual issues vision impaired
bed-wetting diabetic heart conditions stomach problems nightmares
developmental delay emotional illness behavioral issues learning disability
high blood pressure ADD/ADHD other _____

Please explain any marked conditions _____

Adult or Child Participant Name _____
Last First Middle

RECENT MEDICAL TREATMENT OR ILLNESS (please describe) _____

Has the participant had recent exposure to contagious disease? _____

The Camp Health Officer shall administer any "as needed" stock medications from the infirmary/clinic including, but not limited to the following: Acetaminophen (Tylenol), Ibuprofen (Motrin), Diphenhydramine (Benadryl), Sudafed, PeptoBismol, Calamine Lotion, Tums, Hydrocortisone Cream, Antibiotic Ointment, Eye Drops. Please indicate if there are any of the above you do not want the participant to receive.

MEDICATIONS (prescribed and over-the-counter) BROUGHT FROM HOME TO BE TAKEN AT CAMP:

Medication _____ Dosage _____ Time _____ Used for _____

Medication _____ Dosage _____ Time _____ Used for _____

Medication _____ Dosage _____ Time _____ Used for _____

Medication _____ Dosage _____ Time _____ Used for _____

Medication _____ Dosage _____ Time _____ Used for _____

Regular medications that will NOT be taken at camp: _____

IMPORTANT NOTE: *Camp is similar to school environment. Many campers are more successful taking medications normally taken during school. ALL medications (prescriptions, over-the-counter, vitamins, aspirin, etc.) MUST BE IN ORIGINAL CONTAINERS and given to the Camp Health Officer at check-in. All unused medications shall be returned to you. This pertains to all adult and child campers, volunteers, & staff.*

AUTHORIZATION for TREATMENT:

This health information/history is correct and complete to the best of my knowledge. The participant has no physical or mental disabilities that would impair their participation except as noted. All medications (prescribed & over-the-counter) shall be given to the Camp Health Officer upon arrival at camp. I authorize trained staff to provide first aid, the Camp Health Officer to assess injuries and illnesses, and to administer certain medications as indicated.

A camp doctor is available to the Camp Health Officer for consultation or medical assessment and/or treatment. In the event of serious illness or injury, I authorize the physician and/or hospital to undertake such treatment of and perform such services (including surgical) for the participant as are reasonably indicated by the circumstances. I give the camp permission to arrange necessary related transportation for medical treatment for me/my child.

The health information provided is for the purpose of safe camp experience and to meet the health care needs of the participant. The information shall be kept private and confidential, shared only as absolutely needed for the health and safety of the participant or with other medical providers in the event of an emergency.

Signature of LEGAL Parent/Guardian or Adult Participant _____ Date _____

MEDICAL PRACTITIONER'S HEALTH CARE RECOMMENDATIONS:

Must be completed & signed by medical personnel

Printed Name of Medical Practitioner: _____ Title: _____

Address: _____ Telephone: (____) _____

Date of last health exam _____. (NOTE: NH law REQUIRES physical exam WITHIN 2 YEARS of camp arrival.)

Health History: I concur with the listed *medications, immunizations, and health history* on both sides of this form:
yes no: This person is under the care of a medical practitioner for the following additional conditions and listed medications/treatments: _____

Treatment to be continued at camp: _____

Description of any limitation or restriction on camp activities: _____

Additional information for camp nurse and staff to be aware of: _____

Immunizations: Immunizations are all current: yes no **PLEASE ATTACH DOCUMENTATION OF IMMUNIZATIONS**

Camp Participation: In my opinion, the above participant: is is not able to participate in an active camp program.

Signature of Licensed Medical Practitioner: _____ Date: _____