

WILLOW LAKE DAY CAMP  
P.O. Box 1266, Highland Park, NJ 08904

This side to be filled out by physician:

WILLOW LAKE DAY CAMP MEDICAL FORM-2010

Name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_

In my opinion the above applicant having been examined by me on \_\_\_\_\_  
 is  is not able to participate in an active camp program.

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_

General health and circulation: \_\_\_\_\_

Nutrition: \_\_\_\_\_ Eyes: \_\_\_\_\_ Ears: \_\_\_\_\_ Throat: \_\_\_\_\_

Respiratory system: \_\_\_\_\_

Serious illnesses, accidents: \_\_\_\_\_

List any allergies below: Please be sure to describe the reaction and management of the reaction.

Medication allergies: \_\_\_\_\_

Food allergies: \_\_\_\_\_

Other allergies: (include bee stings, asthma, animal dander, etc.) \_\_\_\_\_

Please list any medication child is taking or has taken in the last 6 month. \_\_\_\_\_

Which of the following has the participant had?

Measles  Chicken Pox  German Measles  Mumps  Hepatitis

TB Mantoux Test Date of last test: \_\_\_\_\_ Result: \_\_\_\_\_

Immunizations: Please give all dates

Vaccine	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DPT	_____	_____	_____	_____	_____
TD	_____	_____	_____	_____	_____
Tetanus	_____	_____	_____	_____	_____
Polio	_____	_____	_____	_____	_____
MMR	_____	_____	_____	_____	_____
Or Measles	_____	_____	_____	_____	_____
Or Rubella	_____	_____	_____	_____	_____
Or Mumps	_____	_____	_____	_____	_____
HiB	_____	_____	_____	_____	_____
HepB	_____	_____	_____	_____	_____
Varicella	_____	_____	_____	_____	_____
BCG	_____	_____	_____	_____	_____

Name of physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

SIGNATURE of physician: \_\_\_\_\_

CAMPER NAME: \_\_\_\_\_ Age at camp: \_\_\_\_\_

Home Address: \_\_\_\_\_  
 Parent/Guardian \_\_\_\_\_  
     Home Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
     Business Address \_\_\_\_\_ Phone: \_\_\_\_\_  
 2<sup>nd</sup> Parent/Guardian \_\_\_\_\_  
     Home Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
     Business Address: \_\_\_\_\_ Phone: \_\_\_\_\_

If the above are not available, please contact:  
 :  
 Name \_\_\_\_\_ Name \_\_\_\_\_  
 Phone \_\_\_\_\_ Relation \_\_\_\_\_ Phone \_\_\_\_\_ Relation \_\_\_\_\_

HISTORY: (Check and give dates) A full and complete health history is necessary for us to provide the best care for your child.

Frequent ear infections _____	Chronic conditions _____	Asthma _____
Heart defect/disease _____	Recent Surgery _____	Other _____
Convulsions _____	Frequent headaches _____	
Diabetes _____	Head injury _____	
Bleeding disorders _____	Seizures _____	
Hypertension _____	Back Problems _____	
Mononucleosis _____	Skin Problems _____	

If your child has any of the above conditions, please explain in detail below:  
 \_\_\_\_\_  
 \_\_\_\_\_

Please describe any restrictions to activity required for your child and explain: \_\_\_\_\_  
 \_\_\_\_\_

Is your child on any medication? Yes/No (Please circle one) If yes, please list:  
 \_\_\_\_\_

Is your child on any regular medication that he/she will be taken off of for the summer? Please explain.  
 \_\_\_\_\_

Insurance Information: Carrier or plan Name \_\_\_\_\_ Group# \_\_\_\_\_  
 Carrier Address: \_\_\_\_\_  
 Name of insured: \_\_\_\_\_ Relationship \_\_\_\_\_  
 Social Security # of policy holder or insurance ID# \_\_\_\_\_

PERMISSION TO PROVIDE NECESSARY TREATMENT OR EMERGENCY CARE:  
 I hereby give permission to the medical personnel selected by the camp director to order x-rays, routine tests and treatment for my child in the event that I can not 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 injection and /or anesthesia and /or surgery for my child as named above. This form may be photocopied for use out of camp.

Signature of Parent/guardian: \_\_\_\_\_ Date: \_\_\_\_\_

MEDICAL AUTHORIZATION

I \_\_\_\_\_, parent or guardian of \_\_\_\_\_, authorize any physician, nurse or other health care provider, to communicate with the medical staff and director of Willow Lake Day Camp, or his/her designee, about my child's medical condition, treatment, and/or prognosis.  
 We further authorize the camp administrative and/or medical staff to discuss any medical conditions with the director, his/her designee, or the child's counselor when they, in their sole discretion, believe such communication to be in the best interest of the child. These authorizations are limited to June 28th, 2010 through August 20th, 2010.

Signed: \_\_\_\_\_ Dated: \_\_\_\_\_