



Hi-Hills Day Camp Health History Form

Please mail this form by May 1st to:
Hi-Hills Day Camp
PO Box 604
Gladstone, NJ 07934

**Campers will not be admitted to
camp without this form.**

(This form can not be used for Teen Travel)

Name _____ Birth Date ____/____/____ Age at camp (6/25/12) _____ Gender _____

Home Address _____

Street City State Zip

Custodial parent/guardian _____ Phone _____

Home Address _____

Street City State Zip

Business Address _____

Street City State Zip

Second parent or guardian or emergency contact _____ Phone _____

Home Address _____

Street City State Zip

Business Address _____

Street City State Zip

Physician's Name _____ Physician's Phone Number _____

Date of the most recent physical exam (month/year) ____/____ (must have current physical w/in past 24 months)

Is the participant covered by family medical/hospital insurance? Yes No

Is so, indicate carrier or plan name _____ Group # _____

Photocopy of front and back of health insurance card must be attached to this form.

Please indicate any allergies in the following categories.

Medication _____

Food _____

Other _____

Please explain if the camper has any restrictions to activity while at camp _____

Please explain any dietary restrictions that your child may have _____

Please check all that apply. The camper has/does:

- | | |
|--|--|
| <input type="checkbox"/> a recent injury, illness or infectious disease? | <input type="checkbox"/> Had seizures? |
| <input type="checkbox"/> a chronic or recurring disease? | <input type="checkbox"/> Had a head injury? |
| <input type="checkbox"/> Frequent headaches? | <input type="checkbox"/> Problems with joints? |
| <input type="checkbox"/> Had surgery? | <input type="checkbox"/> Skin problems? |
| <input type="checkbox"/> Nose or sinus problems? | <input type="checkbox"/> Diabetes? |
| <input type="checkbox"/> Frequent ear infections? | <input type="checkbox"/> Asthma? |
| <input type="checkbox"/> Frequent eye infections? | <input type="checkbox"/> An eating disorder? |
| <input type="checkbox"/> Glasses or corrective lenses? | <input type="checkbox"/> Behavioral Conditions? |
| <input type="checkbox"/> Passed out due to exercise? | <input type="checkbox"/> Problems with diarrhea or constipation? |
| <input type="checkbox"/> Been dizzy during exercise? | <input type="checkbox"/> Heart problems? (High BP, murmur?) |
| <input type="checkbox"/> Wear braces? | |

Please explain any checked statements below. _____

In the event of minor medical emergency or illness, the Camp Nurse has my permission to administer the following OTC medications.

- Tylenol (Acetaminophen) Benadryl Cepacol Lozenges

Please give all dates of immunizations for the following:

Vaccine: Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP						
TD(tetanus/diphtheria)	_____	_____	_____	_____	_____	_____
Tetanus	_____	_____	_____	_____	_____	_____
Polio	_____	_____	_____	_____	_____	_____
MMR	_____	_____	_____	_____	_____	_____
Or Measles	_____	_____	_____	_____	_____	_____
Or Mumps	_____	_____	_____	_____	_____	_____
Or Rubella	_____	_____	_____	_____	_____	_____
Hemophilia influenza B	_____	_____	_____	_____	_____	_____
Hepatitis B	_____	_____	_____	_____	_____	_____
Varicella (chicken pox)	_____	_____	_____	_____	_____	_____

Which of the following has the participant had?

- Measles
- Chicken Pox
- German Measles
- Mumps
- Hepatitis A
- Hepatitis B
- Hepatitis C

Please list any other additional information that would be helpful to ensuring the best care for your child this summer. Please include any physical, emotional, or mental health information about which Hi-Hills Day Camp should be aware. _____

To the best of my knowledge this Health History is correct and complete. The camper has permission to participate in all camp activities unless otherwise noted on this form.

I hereby give permission to **Hi-Hills Day Camp** to provide, seek, and consent to routine medical health care, administration of prescribed medications, and emergency treatment for my child as may be necessary. This includes, but is not limited to: x-rays, routine tests and treatment, and/or hospitalization. I give permission to Hi-Hills to provide and transportation required for treatment. I understand that all medical bills for services to my child rendered by anyone other than the **Hi-Hills Day Camp** staff are my responsibility. I agree to release any records necessary for treatment, billing or insurance purposes.

It is my intention that the camp be treated as acting *in loco parentis* for my child. If I cannot be reached in the event of an emergency, I grant permission to **Hi-Hills Day Camp** to use the physician they have selected to secure treatment, including hospitalization.

Signature of Parent/Guardian _____ Printed Name _____ Date _____

Medication Permission and Physician Instruction

Camper Name _____ Date of Birth _____

Address: _____

Street

City

State

Zip

Parent/Guardian Permission:

I give permission to the camp nurse or those adults authorized in her absence to administer the medications(s) listed below.

Parent Name _____ Home Phone: _____ Work Phone _____

Parent Signature _____ Date _____

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Medication _____

Dose: _____ Frequency: _____

Diagnosis _____

Cautionary Information specific to this medication (Side effects, sensitivities, etc.)

Medication _____

Dose: _____ Frequency: _____

Diagnosis _____

Cautionary Information specific to this medication (Side effects, sensitivities, etc.)

Medication _____

Dose: _____ Frequency: _____

Diagnosis _____

Cautionary Information specific to this medication (Side effects, sensitivities, etc.)

Note: All Medications must be supplied in their original containers with attached prescription or signed instructions from prescribing physician. Any prescriptions not picked up at the end of camp attendance will be destroyed.