



Hi-Hills Teen Travel Health History Form

Please mail this ASAP to:
Hi-Hills Day Camp
PO Box 604
Gladstone, NJ 07934
Fax: 908-234-0045

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

Name _____ Birth Date ____/____/____ Age at camp _____ 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) ____/____

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 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. _____

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 _____

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						
Haemophilus 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 Be Completed by Licensed Medical Personnel

I examined this individual on _____.

BP _____ Weight _____ Height _____

In my opinion, the above applicant is is not able to participate in an active camp program.

Please note any limitations to camp activities _____

Signature of Licensed Medical Personnel _____	
Printed _____	Title _____
Address _____	
Phone _____	Date _____

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 _____



Hi-Hills Camp at Gill St. Bernard's
PO Box 604
Gladstone, NJ 07934
Tel: 908-234-0067 Fax: 908-234-0045
Web: www.hihills.com
Email: hihills@gsbschool.org

Medication Policy

When medication, prescription or over-the-counter, is to be administered to a camper during the camp day, the parents must bring the following to the Camp Nurse:

- Written orders from a physician giving the name of the drug, dosage, when medication is to be taken, diagnosis and/or reason the medication is given.
- Written permission from the Parent or Guardian for the camp to comply with the physician's order.
- Medication in an appropriately labeled pharmacy container and/or an over-the-counter medication in its original container as purchased.

Note: The camp nurse may not administer medication which is not prescribed by a physician.

Medication Permission Form

I hereby authorize the Hi-Hills Camp Nurse or her designated substitute to administer to:

Camper's Name

Medication	Dosage	Time to administer
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Parent's signature

Date

Physician's Authorization

I prescribe (medication, dosage, and time) _____

To be given to: (Camper's Name) _____

By the Camp Nurse or her designated substitute during camp hours for the reason(s) stated below:

Possible side effects or contradictions: _____

Curtailed activity or special instructions: _____

Inhalers only: Is child authorized to carry and self-medicate? Yes _____ No _____

Physician's Signature	Telephone Number	Date
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