Clear Form

OUR KIDS DAY CAMP II, INC.

661 Budd Road **Phone: 845-434-3788**
Woodbourne, NY 12788

CAMP HEALTH FORM

****The Camp Health Form MUST be filled out for each Camper EVERY year. PLEASE fill out both sides COMPLETELY and SIGN****

Camper Name_____ Birth Date_____ Sex_____ Age_____

Parents or Guardian_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Email Address:_____

Home Address_____
Street & Number City State/Zip

If not available in an emergency notify:

1)_____ Phone_____ 2)_____ Phone:_____
Name Name

Health History:

Circle Yes or No		Allergies		Has your camper had:	
Frequent Ear Infections	choose one	Hay Fever	choose one	Chicken Pox	choose one
Heart Defect/Disease	choose one	Poison Ivy	choose one	Measles	choose one
Convulsions	choose one	Insect Stings	choose one	Mumps	choose one
Diabetes	choose one	Penicillin	choose one	ASTHMA	choose one
Bleeding/Clotting Disorders	choose one	Other Drugs:	choose on	if Yes, specify_____	

Operations or serious injuries choose o If yes, indicate what kind and dates_____
Chronic or recurring illness or disease_____
_____

Special Diet? choose o If yes, specify _____

Are there any Activities your child should be restricted from at camp? choose one
If yes, Specify which ones: _____

- **MEDICATION**

ALL MEDICATIONS (OVER THE COUNTER OR PRESCRIBED) MUST BE KEPT IN THE OFFICE. PLEASE BRING ANY MEDICATION BEFORE CAMP STARTS. THE MEDICATION MUST BE IN THE ORIGINAL PRESCRIBED BOTTLE WITH THE TIME AND DOSAGE

Is your child taking any medications? YES/NO If yes, please indicate what kind_____

What is the medication for?_____

Are you sending any kind of medication to camp? choose one

Does your child have any current physical, mental, or psychological conditions? choose one
If yes, any medication, treatment, or special restrictions or considerations, while at camp?_____
_____

IMPORTANT: Please notify the camp if this camper is exposed to any communicable disease during the three weeks prior to camp attendance.

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Name of dentist/orthodontist_____ Phone_____

Name of family physician_____ Phone_____

Do you carry family medical/hospital insurance? YES/NO If yes, Indicate: Carrier:_____
Policy or Group #_____ It is understood that the camper's medical insurance is the primary insurance, in case of medical attention.

IMMUNIZATION HISTORY Please attach a copy of your child's immunization record or indicate in the appropriate area below the date (month and year) of basic immunizations and most recent booster doses.

VACCINES	Date of Basic Immunization	Date of Last Booster
Diphtheria Pertussis (Whooping Cough)}DPT* Tetanus	1 2 3	1 2
Varicella (chicken pox)		
Hepatitis B		
Oral Polio (Sabin) * TOPV Injectable Polio (Salk)		
Haemophilus Influenza type B		
Measles (hard measles, red measles, Rubeola)		
Mumps		
Rubella (German measles, 3-day measles)		
Other		
Tuberculin test given_____(most recent)		

Accidents and injuries occur during sporting activities. Our Kids Day Camp cannot be held responsible for injuries occurring during these activities, nor can we be held responsible for medical expenses due to injuries caused during these activities.

Important –Permission to Treat

Parent's Authorization. This health history is correct. The camper described in this health form has permission to engage in all prescribed camp activities, except as noted.

I hereby give the camp medical personnel permission to treat my child within their medical credentials.

In case parents cannot be notified, in the case of an emergency, I hereby give permission to the physician selected by the camp director to order X-rays, routine tests and treatment for the health of my child. I also 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.

I HAVE READ THE CAMP'S POLICIES AND PROCEDURES WITH MY CAMPER AND WE FULLY UNDERSTAND ALL THE RULES AND REGULATIONS OF OKDC.

Parent Signature:_____ Camper Signature:_____ Date:_____