

TALL PINES DAY CAMP HEALTH FORM

Child's Name _____ Age _____

Address _____

Parent(s) or Guardian (s): (#1) _____ (#2) _____
Home Phone (#1) _____ (#2) _____
Work Phone (#1) _____ (#2) _____
Cell Phone (#1) _____ (#2) _____

In an emergency notify _____ Relationship to Child _____

Address _____

Phone # _____ Work # _____ Cell # _____

Does your child have physical, medical or emotional problems? Yes No

If yes, describe: _____

Does your child take any medications on a daily basis? Yes No

If yes, list medications: _____

Does your child have any known allergic reactions to the following? Bee Sting Peanuts

Chocolate Penicillin Other Foods _____

Other Drugs _____ Seasonal Allergens _____ Other _____

What is your child's usual reaction? Hives Rash Anaphylaxis Other _____

Does the nurse have permission to administer Benadryl if needed for nonspecific rashes or minor allergic reactions? Yes No (Dosage based on child's age or weight.)

Does the nurse have permission to administer (Circle preference) Tylenol/Motrin/Aleve/Advil for headaches or minor discomforts? Yes No Does your child need Liquid or Pill? (Circle preference:).

HEALTH HISTORY: (Please check – giving appropriate dates.)

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Frequent Sore Throats |
| <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Measles | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Abscessed Ears | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Poliomyelitis | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Athlete's Foot | <input type="checkbox"/> Stomach Upsets | <input type="checkbox"/> Sleep Walking | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Serious Ivy, Oak, Sumac Poisoning _____ | | | |

Operations or Serious Injuries _____

Any Allergies _____

Emotional Stability: Much Some Little None

Maturity: Much Some Little None

Any Personal Problems: Much Some Little None

Any Behavior Problems: Explain _____

Any Learning Problems: Explain _____

Recommendations/Restrictions (Diet, medicine, swimming, running, etc.) _____

IMMUNIZATIONS: (Write approx. date of immunization.) DPT Series _____ Tetanus _____

Polio _____ Measles (MMR) _____ Haemphilis (Hib) _____

Is child up to date with Tetanus vaccine or Tetanus booster shot? Yes No

In case of emergency, I understand every effort will be made to contact parents/guardian of camper. In the event that I cannot be reached, I hereby give permission to the physician selected by the Director to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child, as named above.

Parent Signature _____ Date _____

Physician's Name _____ Physician's Phone _____

Date of Last Physical Exam _____ Physician's Signature _____

Mail to: Tall Pines Day Camp, 1349 Sykesville Road, Williamstown, NJ 08094
Fax to: (856) 262-0195