



Camp Medical Release Form

Complete and return **before** your child's camp program.

One form per child is required to participate in camp.

The information on this form is not part of the camper or staff acceptance process but is gathered to assist us in identifying appropriate care. Provide complete information so that the staff can be aware of your child's needs. Any changes to this form should be submitted to camp personnel upon participant's arrival in camp.

Camper's- First Name _____ Last Name _____

Birth date _____ Grade Entering _____ Male Female

Address _____

City _____ State _____ Zip Code _____

Parents'/Guardians' - First Name _____ Last Name _____

Address _____ Cell # _____
(If different from above)

Email _____ Home # _____

Parents'/Guardians'/Emergency contact- First Name _____ Last Name _____

Address _____ Cell # _____
(If different from above)

Email _____ Home # _____

Emergency contact- First Name _____ Last Name _____

Address _____ Cell # _____
(If different from above)

Relationship _____ Home # _____

Important—This box must be completed for attendance

I, the undersigned, hereby give permission for my child to participate in all activities (unless otherwise specified) and assume all risks and hazards incidental to the program. I also hold harmless Tenafly Nature Center, its staff and appointed assistants. I, also understand and agree to abide by any restrictions placed on my participation in camp activities.

Parent/Guardian Authorizations: This health history and any attached forms are correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted.

I hereby give permission to Tenafly Nature Center to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes. I give permission to the staff to arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency. I hereby give permission to the physician selected by the staff to secure and administer treatment, including hospitalization, for the camper named above. This completed form may be photocopied.

Signature of parent or guardian or adult camper/staffer _____

Printed Name _____ Date _____

Special needs– List any which the staff should be aware of (medical, emotional, learning)

Allergies- Include medication, food and others (insect stings, hay fever, asthma, animal dander, etc.)

List all known	Describe reaction and management of the reaction.
_____	_____
_____	_____
_____	_____
_____	_____

Restrictions (The following restrictions apply to this individual). Kosher Vegetarian

Does not eat: Meat Pork Dairy products Wheat Peanuts Eggs Other _____

Explain any restrictions to activity (e.g., what cannot be done, what adaptations or limitations are necessary)

Medications

Please list ALL medications (including over-the counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

This person **takes NO medications** on a routine basis. OR This person **takes medications** as follows:

Med #1 _____ Dosage _____ Specific times taken each day _____
 Reason for taking _____

Med #2 _____ Dosage _____ Specific times taken each day _____
 Reason for taking _____

Attach additional pages for more medications.

Identify any medications taken during the school year that participant does/may not take during the summer:

Health History (Explain "yes" answers below)

Has/does the participant:		Yes	No			Yes	No
1. Had any recent injury, illness or infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	15. Ever been diagnosed with a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have a chronic or recurring illness/condition?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	16. Ever had back problems?.....	<input type="checkbox"/>	<input type="checkbox"/>
3. Ever been hospitalized?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	17. Ever had problems with joints (e.g., knees, ankles)?.....	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever had surgery?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	18. Have an orthodontic appliance being brought to camp?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have frequent headaches?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	19. Have and skin problems (e.g., itching, rash, acne)?.....	<input type="checkbox"/>	<input type="checkbox"/>
6. Ever had a head injury?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	20. Have diabetes?.....	<input type="checkbox"/>	<input type="checkbox"/>
7. Ever been knocked unconscious?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	21. Have asthma?.....	<input type="checkbox"/>	<input type="checkbox"/>
8. Wear glasses, contacts or protective eye wear?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	22. Had mononucleosis in the past 12 months?.....	<input type="checkbox"/>	<input type="checkbox"/>
9. Ever had frequent ear infections?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	23. Had problems with diarrhea/constipation?.....	<input type="checkbox"/>	<input type="checkbox"/>
10. Ever passed out during or after exercise?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	24. Had problems with sleepwalking?.....	<input type="checkbox"/>	<input type="checkbox"/>
11. Ever been dizzy during or after exercise?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	25. If female, have an abnormal mensrual history?.....	<input type="checkbox"/>	<input type="checkbox"/>
12. Ever had seizures?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	26. Have a history of bed-wetting?.....	<input type="checkbox"/>	<input type="checkbox"/>
13. Ever had chest pain during or after exercise?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	27. Ever had an eating disorder?.....	<input type="checkbox"/>	<input type="checkbox"/>
14. Ever had high blood pressure?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	28. Ever had emotional difficulties for which professional help was sought?.....	<input type="checkbox"/>	<input type="checkbox"/>

Please explain "yes" answers, noting the number of questions. _____

Which of the following has the participant had?

- Measles Chicken pox German measles Mumps Hepatitis A Hepatitis B Hepatitis C

Immunization dates

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)		_____	_____	_____	_____	_____	_____

TB Mantoux Test: Date of last test _____ Result: Positive Negative

Insurance Information

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

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

Carrier address _____

Name of insured _____ Relationship to participant _____

Social Security number of policy holder or Insurance ID number _____

Camper's physician _____ Phone _____

Address _____

Camper's dentist/orthodontist _____ Phone _____

Address _____