Both Sides must be **COMPLETED** to register camper.

Summer Rec Health Examination Form

Saugerties Summer Recreation Program 20_____

_____ **Group**

A parent or guardian must fill out this form.

Name _____ Birth Date____/____/____ Gender M or F Age _____

Parent or Guardian _____ Phone _____

Address _____ Cell/Pager_____

Street & No. Include Area Code

_____

City State Zip

Emergency Info: If the above person is not available in an emergency, please notify:

(1) Name_____Relationship_____ Phone/Cell _____

_____

Street & No. City State Zip

(2) Name_____Relationship_____ Phone/Cell _____

_____

Street & No. City State Zip

HEALTH HISTORY

Check & give approximate dates if applicable.

General

Ear Infections _____
Convulsions _____
Diabetes _____
Behavior _____

Allergies

Hay Fever _____
Poison Ivy, etc. _____
*Insect Stings _____
Penicillin _____
Other Drugs _____

Diseases

Chicken Pox _____
Measles _____
German Measles _____
Mumps _____
*Asthma _____

Please list special needs or any other health conditions. _____

*****Medications at camp_____Dosage_____**

*Where would you like the medications kept? Medical Box or First Aid Fanny Pack

* Other medications not given at camp_____ Dosage _____

* Medications to be given at camp will need a Doctor's order. See nurse for needed forms.

Recommendations and Restrictions while at Recreation.

Special diet (indicate Food Allergies) _____

Strenuous Activity _____

Other _____

OVER

IMPORTANT: *Please notify the camp if this camper was exposed to any communicable diseases during the three weeks prior to camp attendance.*

IMMUNIZATION RECORDS

*Please indicate **dates** of immunizations series.*

Diphtheria Dates Tetanus Pertussis	Haemophilis Dates Influenza	Polio Dates	Measles Dates Mumps Rubella	Varicella Dates (Chickenpox)	Hepatitis B Dates
Dt TaP 1 - _____	Hib 1 – _____	IPV 1 - _____	MMR 1 – _____	Var 1 – _____	HepB 1- _____
Dt TaP 2 - _____	Hib 2 – _____	IPV 2 - _____	MMR 2 - _____	Var 2 – _____	HepB 2 – _____
Dt TaP 3 - _____	Hib 3 – _____	IPV 3 - _____			HepB 3 – _____
Dt TaP 4 - _____	Hib 4 – _____	IPV 4 - _____			
Dt TaP 5 - _____					

Tetanus Booster_____

You MUST indicate DATES for each.
UP –o- DATE is* NOT *Acceptable

Family Physician/ Pediatrician

Name_____

Phone _____

Address _____

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities, except as noted by our family physician / pediatrician or me.

Parent/Guardian _____ Date_____
Signature

IMPORTANT : MEDICAL AUTHORIZATION

In case of emergency, I understand every effort will be made to contact me. In the event that our family physician/pediatrician, or I, the undersigned, cannot be reached in an **EMERGENCY**, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child as named above.

_____ _____
Parent/Guardian Signature Date