

**EAGLE RIVER DAY CAMP**  
**2011 Health and Medical Record**

Grade next Sept. \_\_\_\_\_

**DIRECTIONS:** Please complete PAGES 1-3 of this form and SIGN ON PAGE 3. Return this form by May 15.

Camper/Staff Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Age on July 1 \_\_\_\_\_ Gender \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Home Phone \_\_\_\_\_

This person is a  Camper  Staff Staff Cell Phone \_\_\_\_\_

Father's Full Name: \_\_\_\_\_ Mother's Full Name: \_\_\_\_\_

Business Phone: Father ( ) \_\_\_\_\_ Mother ( ) \_\_\_\_\_

Cellular Phone: Father ( ) \_\_\_\_\_ Mother ( ) \_\_\_\_\_

**IN AN EMERGENCY PLEASE NOTIFY:** We will always attempt to contact the parents first. Please provide the names of emergency contacts (other than a parent) who are close to camp and available during the day.

Name \_\_\_\_\_ Name \_\_\_\_\_

Address \_\_\_\_\_ Address \_\_\_\_\_

Relationship \_\_\_\_\_ Relationship \_\_\_\_\_

Phone: Home \_\_\_\_\_ Other \_\_\_\_\_ Phone: Home \_\_\_\_\_ Other \_\_\_\_\_

**ALLERGIES:**

- This person has no known allergies.
- This person is allergic to  Food  Medicine  The environment (insect stings, hay fever, etc.)  Other  
*Please describe below all known allergies, the reaction seen and management of the reaction.*

**DIET, NUTRITION:**

- This person eats a regular diet.  This person eats a regular vegetarian diet.
- This person has special food needs. *(Please describe below)*

**RESTRICTIONS:**

- I have reviewed the program and activities and feel this person can participate without restrictions.
- I have reviewed the program and activities and feel this person can participate with the following restrictions or adaptations. *(Please describe below)*

**MEDICAL INSURANCE INFORMATION:**  Yes  No This person is covered by family medical / hospital insurance.

*Include a copy of your insurance card if appropriate; copy both sides so information is readable.*

Insurance Company \_\_\_\_\_ Policy Number \_\_\_\_\_

Subscriber Name \_\_\_\_\_ Insurance Company Phone # ( ) \_\_\_\_\_

**HEALTH CARE PROVIDERS:**

Primary doctor(s): \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Primary dentist(s): \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Primary orthodontist(s): \_\_\_\_\_ Phone ( ) \_\_\_\_\_

**IMMUNIZATION HISTORY :** Provide the month and year for each immunization. Diamond ( ♦ ) immunizations must be current. Copies of immunization forms from health care providers or state or local government are acceptable; please attach to this form.

Which of the following has the participant had?

- Measles
- Chicken pox
- German measles
- Mumps
- Hepatitis

**This section must  
be completed per  
NJ State Law**

Date	Vaccine
_____	Diphtheria, tetanus, pertussis ♦ (DtaP or TdaP)
_____	Tetanus booster ♦ (dT or TdaP)
_____	Mumps, measles, rubella ♦ (MMR)
_____	Polio ♦ (IPV)
_____	Haemophilus influenza type B (HIB)
_____	Pneumococcal (PCV)
_____	Hepatitis A
_____	Hepatitis B
_____	Varicella Zoster (Chicken pox)
_____	Meningococcal meningitis (MCV4)

Date of last Tuberculosis (TB) test \_\_\_\_\_

Result:  Positive  Negative

*If this person has not been fully immunized, please sign the following statement:*

I understand and accept the risks for not being fully immunized.

\_\_\_\_\_  
Parent or Legal Guardian's Signature  
Applicant's Signature (if over 18)

\_\_\_\_\_  
Date

**MEDICATION:** Please list ALL medications (including over-the-counter or non-prescription drugs) taken routinely. Medications to be dispensed at camp must be supplied in the original packaging that identifies the patient, medication, dosage, frequency, and prescribing physician. Medications must not be expired. Attach additional pages for more medications. Please check one of the two boxes below:

- This person takes NO medications on a routine basis
- 

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 \_\_\_\_\_

Med #3 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_

Reason for taking \_\_\_\_\_

Identify any medications taken during the school year that participant does/may not take during the summer and/or any prescription medication not taken on a regular basis:

**TREATMENT:** The following non-prescription medications may be stocked in the Wellness Center and are used on an as needed basis to manage illness and injury. ***Cross out those that this person should NOT be given.***

Acetaminophen (Tylenol)

Ibuprofen (Advil, Motrin)

Antibiotic cream

Antihistamine/allergy medicine (Benadryl or Generic)

Calamine lotion or Generic substitute

Bismuth subsalicylate for diarrhea (Pepto-Bismol)

Sore throat spray or lozenge (Cepacol or Generic)

Sunburn spray (Solarcaine or Generic)

Sting swabs (Benzocaine)

