



Rambling Pines Day Camp

Camper Health History Form

Keep a copy of this form for your records

Please have all health forms submitted to camp by June 6, 2011 regardless of when your child will be attending camp. Feel free to submit health forms prior to payment. For everyone's safety, children will not be allowed to attend camp without a completed health form.

- Please attach a copy of your child's **immunization records**, even if they are a returning camper. If you have a religious exemption, please attach the exemption letter.
- **NO PHYSICAL EXAM OR DOCTOR'S SIGNATURE IS REQUIRED.**

Camper Name _____ Weeks Attending Camp: _____

Address _____ City _____

State _____ Zip Code _____

Date HF Completed _____ Date of Birth _____ Age _____ Height _____ Weight _____

PLEASE CIRCLE WHICH NUMBER TO CALL FIRST

Home Phone _____ Home Email _____

Parent/Guardian #1 _____ Phone #1 _____ Phone #2 _____

Parent/Guardian #2 _____ Phone #1 _____ Phone #2 _____

Child lives with: _____

EMERGENCY CONTACT: In the event that neither parent/guardian can be contacted, please be sure this person is aware of his/her responsibility and will be available to pick up your camper.

Name _____ Phone #1 _____ Phone #2 _____ Phone #3 _____

INSURANCE INFORMATION (In case of emergency, this information will be required at any medical facility.)

Name of insurance company _____ ID# _____ Group # _____

Name of Policy Holder: _____ Relationship to Camper: _____

In the event of an emergency I prefer the following hospital: _____ Hunterdon Medical Center _____ Mercer Medical Center
_____ Princeton Medical Center _____ Other: _____

Does your child have any allergies? Please list allergy and reaction below.

- No Known Allergies Drug Food Environmental

Camper Name: _____

CAMP APPROVED OVER-THE COUNTER (OTC), AS NEEDED (PRN) MEDICATIONS. Please mark the columns below indicating which medications you give camp nurses permission to administer, for minor problems, if needed. For your convenience, the camp health office has all these medications. There is no need for you to send them in for your child.						
acetaminophen (Tylenol)	diphenhydramine (Benadryl)	ibuprofen Advil, Motrin	antacids Tums, Maalox	pseudoephedrine Sudafed	Visine Eye Drops	alcohol ear drops Swim Ear
_____	_____	_____	_____	_____	_____	_____

- I give permission to the camp nurse to give the OTC PRN medications INITIALED above.
- I do not wish any OTC PRN medications to be given to my child at camp.
- I want to be notified BEFORE any OTC PRN medications are given to my child at camp.

Please list below all medications that your child is taking, whether it be daily medication or only if your child needs it. Please indicate whether the medication will need to be administered while at camp. All **medications** must be at camp **2 weeks before the child's FIRST DAY OF CAMP**.

- ▶ All prescription (**Rx**) medications must have a **clear, current, original Rx label, affixed to the container**.
- ▶ All **OTC** medications must be **in the original manufacturer's container with clearly readable manufacturer's directions and ingredients**.
- ▶ Expiration dates must be readable on all medications. **No medications will be given passed their expiration date.**
- ▶ Family members **may not share Rx medications**.

MEDICAL/PHYSICAL/EMOTIONAL CONDITIONS - Please check all that are apply and explain on the next page.

- | | | |
|---------------------------------------------------------------------------------------|-----------------------------------------------------------------|----------------------------------------------------------------------------|
| <input type="checkbox"/> ADD/ADHD on daily medication | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Menstrual Pain |
| <input type="checkbox"/> ADD/ADHD not taking daily medication | <input type="checkbox"/> Ear Problems | <input type="checkbox"/> Mononucleosis |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Mood Disorder |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Emotional Issues | <input type="checkbox"/> Neuro-muscular Condition |
| <input type="checkbox"/> Auditory Processing | <input type="checkbox"/> Enuresis (bed wetting) | <input type="checkbox"/> Nervous Disorders |
| <input type="checkbox"/> Asperger's Syndrome | <input type="checkbox"/> Eyes/Vision Issues | <input type="checkbox"/> Nose Bleeds |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting/Passing Out | <input type="checkbox"/> Obsessive Compulsive Disorder(OCD) |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Fatigue & Undue Tiredness | <input type="checkbox"/> Orthopedic Problem |
| <input type="checkbox"/> Back/Spine Issues | <input type="checkbox"/> Fracture in the last 18 months | <input type="checkbox"/> Persistent Cough |
| <input type="checkbox"/> Behavioral Issues | <input type="checkbox"/> Fungus Infections | <input type="checkbox"/> Recent Weight Loss/Gain |
| <input type="checkbox"/> Blackouts | <input type="checkbox"/> Genitalia Issues | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Bladder Problem | <input type="checkbox"/> Growth Problems | <input type="checkbox"/> Skin Issues |
| <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> Headaches | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Stomach Issue (ulcer, etc.) |
| <input type="checkbox"/> Bus Sickness | <input type="checkbox"/> Heart Problems (rheumatic fever, etc.) | <input type="checkbox"/> Seasonal Allergies, does not take meds regularly |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hearing Aids | <input type="checkbox"/> Seasonal Allergies, takes meds daily |
| <input type="checkbox"/> Cardiac Issues: ever needed EKG, echo, etc. | <input type="checkbox"/> Heat Related Problems | <input type="checkbox"/> Sun Sensitivity |
| <input type="checkbox"/> Chlorine Sensitivity (eyes) (must provide goggles from home) | <input type="checkbox"/> Hernia (rupture) | <input type="checkbox"/> Throat Issues |
| <input type="checkbox"/> Chlorine Sensitivity (skin) | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tourette Syndrome |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Hives | <input type="checkbox"/> Traveled out of the country in the last 12 months |
| <input type="checkbox"/> Clotting Disorder | <input type="checkbox"/> Immune Deficiency | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Concussion | <input type="checkbox"/> Joint Issues | <input type="checkbox"/> Wheezing |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Jaw/ Teeth Issues / Braces | <input type="checkbox"/> Other medical, physical, emotional conditions |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lactose Intolerant | |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Liver Issues (hepatitis, etc.) | |
| | <input type="checkbox"/> Lyme's Disease | |

Camper Name: _____

If you answered "yes" to any of the conditions listed above, please explain in the space below. Give the date and outcome of all conditions above or any conditions or medical history not listed. You may attach additional sheets and medical records if necessary.

Does your child have any eating problems or special diets? YES NO If yes, please explain

PLEASE CHECK WITH THE CAMP OFFICE NO LATER THAN 3 WEEKS PRIOR TO THE 1ST DAY OF CAMP TO ARRANGE MEDICALLY NECESSARY DIETS. CAMPERS WITH SEVERE FOOD ALLERGIES ARE EXPECTED TO BRING IN THEIR OWN FOOD, WHICH WILL BE SAFELY STORED BY CAMP STAFF.

Does your child have any condition which might limit his/her activities at camp? YES NO If yes, please explain

Does your child have any current restriction from physical/sports activities? YES NO If yes, please explain

Please list any surgeries, hospital admissions (medical or psychiatric), serious diseases, accidents or emergency room visits:

If you have any other comments or concerns about your child's health, development, behavior, family or home life that you would like the camp to be aware of, please explain.

Regrettably, because of the increasing number of severe food allergies, we cannot allow outside food to be brought in for sharing for any reason, including birthday parties or other celebrations. By signing this document, you acknowledge that you've read and understand this policy.

AUTHORIZATION FOR HEALTH CARE AT RAMBLING PINES DAY CAMP: I hereby give permission to Rambling Pines Day Camp to provide first aid treatment for minor injury or illness and to provide and arrange for emergency treatment of other illnesses or injury in the event that the camper's parent or guardian cannot be promptly contacted. I give permission to Rambling Pines Day Camp to administer medications as I have indicated. I give permission to Rambling Pines Day Camp to photocopy this form to accompany camper for emergency medical treatment and for trips off grounds. I certify that my child's health history form is in all aspects correct and complete.

Parent/Guardian Signature

Date