Health History

Camper Name:_____ Gender:_____ DOB:_____ Age:_____ Grade in Sept:_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____

Parent Name:_____ Cell Phone:_____ Work Phone:_____

Parent Name:_____ Cell Phone:_____ Work Phone:_____

Medical History (Required by the New Jersey Department of Health & Safety)

Doctor Name:_____ Phone Number:_____

Insurance Carrier:_____ Policy #:_____

Immunization History: Please record the date (month and year) of the basic immunizations and most recent booster. If you have any questions, check with your doctor. **Physician's signature is NOT required unless your child needs to be administered medication. Dates are required either filled in or attached.**

DBT Booster:_____ Tetanus Booster:_____ Polio OPV (Sabin):_____ MMR:_____

Pertussis:_____ HBV:_____ HIB:_____ HIB:_____

HIB:_____ Varicella:_____ Tuberculin Test:_____ Result:_____

Date of last medical exam:_____

Food Allergies: _____

Medication Allergies:_____

Does the child carry an asthma inhaler?_____ Will you be sending an Epipen to camp?_____

Operations or serious injuries (dates):_____

Chronic or recurring illness including seizure:_____

List all medications that your child is currently taking:_____

_____

Please list any additional health history information we should be aware of:_____

_____

Please check if you would like to be contacted by our behavior specialist. ☐

Parent Authorization: This health history is correct and complete. The camper described in this form has permission to engage in all camp activities unless otherwise noted. I hereby grant permission to YMCA Camp Topanemus to provide routine health care, administer prescribed medications and seek emergency treatment if necessary. In the event that I cannot be reached in an emergency, I hereby grant Camp Topanemus to secure and administer treatment.

Signature of Parent/Guardian:_____ Date:_____

Medication Permission Form:

I hereby request the following medication to be given to my child at the prescribed time and dosage by the camp Nurse. This applies to over-the-counter medication. No medication will be given unless the information below is filled out in detail and signed by a licensed physician. All medication is to be brought to camp in the original contained labeled by the pharmacy. Medications must be delivered to the camp office by an adult. All medications will be kept in locked storage area. Medications will be returned only to the parent.

Medication: _____ Dosage:_____ Specific Time:_____ Diagnosis:_____

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A physician is to sign this form if medication will be administered to your camper.

Physician Signature:_____ Printed Name:_____ Date:_____

Parent Signature:_____ Printed Name:_____ Date:_____