

**MILL ROAD DAY CAMP  
2010 CAMPER PERSONAL HEALTH AND MEDICAL RECORD**

**DIRECTIONS: PARENT OR GUARDIAN MUST COMPLETE ALL PAGES**

Please print all information clearly

Camper's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State & Zip: \_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_

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

Mother's Work Phone: ( ) \_\_\_\_\_ Father's Work Phone: ( ) \_\_\_\_\_

Mother's Cell Phone: ( ) \_\_\_\_\_ Father's Cell Phone: ( ) \_\_\_\_\_

**IN A MEDICAL EMERGENCY WE WILL MAKE EVERY EFFORT TO CONTACT THE PARENT(S) OR GUARDIAN**

Please provide names of emergency contacts who are close to the camp and available during the day:

Name: \_\_\_\_\_ Name: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Relationship: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_ Phone: \_\_\_\_\_

Home: ( ) \_\_\_\_\_ Work: ( ) \_\_\_\_\_ Home: ( ) \_\_\_\_\_ Work: ( ) \_\_\_\_\_

Cell: ( ) \_\_\_\_\_ Cell: ( ) \_\_\_\_\_

**\*\*\*If parent is employed at Mill Road, please complete:** Parent Name: \_\_\_\_\_ Assignment: \_\_\_\_\_

**INSURANCE INFORMATION:**

Is the camper covered by family medical/hospital insurance? Yes [ ] No [ ]

If so, indicate you carrier or plan name \_\_\_\_\_ Group # \_\_\_\_\_

Name of Insured \_\_\_\_\_ Relationship to camper \_\_\_\_\_

Insurance ID number \_\_\_\_\_

**HEALTH HISTORY**

Parent/Guardian Authorizations: This health history is correct and complete as far as I know. The person herein described has permission to engage in all camp activities except as noted.

I hereby give permission to the camp to provide routine health care and administer prescribed medications. In the event that I, the parent/guardian of the camper listed above cannot be reached or in a situation deemed to be an emergency by Mill Road Day Camp, I hereby give permission to Mill Road Day Camp to order x-rays, routine tests, treatment and transportation to a physician or hospital for the camper. I also give permission to the physician or hospital selected by Mill Road Day Camp to administer treatment, including hospitalization, for the person named above. This form may be photocopied for trips and all other needs of the camp.

Printed Name of parent/guardian \_\_\_\_\_ Date \_\_\_\_\_

Signature of parent/guardian \_\_\_\_\_

The following information must be filled in by the parent/guardian for the camper listed. The intent of this information is to provide camp health care personnel with the necessary background information to provide adequate care. Please keep a copy of this completed form for your records. Any changes to this form must be supplied to the camp health personnel immediately.

**ALLERGIES:** list all known Describe reaction and management of the reaction.

Medication allergies (list)

\_\_\_\_\_  
\_\_\_\_\_

Food allergies (list)

\_\_\_\_\_  
\_\_\_\_\_

Other allergies (list) - include insect stings, hay fever, asthma, animal dander, etc.

\_\_\_\_\_  
\_\_\_\_\_

**MEDICATIONS BEING TAKEN:** Please list all medications (including over-the-counter or nonprescription drugs) taken routinely. Medications must be supplied in the original packaging that identifies the medication, dosage, frequency, and prescribing physician.

The above listed person takes NO medications on a routine basis.

The above listed 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 that are taken during the year that the your child will not be taking during the summer.

Medication \_\_\_\_\_ Reason for not taking during summer \_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

**GENERAL QUESTIONS:** Explain “yes” answers below.

Has the camper

Yes No

- 1. Had any recent injury, illness or infectious diseases?
- 2. Have a chronic or recurring illness/condition?
- 3. Ever been hospitalized?
- 4. Ever had surgery?
- 5. Have frequent headaches?
- 6. Ever had a head injury?
- 7. Ever been knocked unconscious?
- 8. Wear glasses, contacts or protective eye wear?
- 9. Ever had frequent ear infections?
- 10. Ever passed out during or after exercise?
- 11. Ever been dizzy during or after exercise?
- 12. Ever had seizures?
- 13. Ever had chest pains during or after exercise?
- 14. Ever had high blood pressure?
- 15. Ever been diagnosed with a heart murmur?

Yes No

- 16. Ever had a heart attack?
- 17. Ever had back problems?
- 18. Ever had problems with joints (e.g. Knees, ankles)?
- 19. Have an orthodontic appliance being brought to camp?
- 20. Have any skin problems (e.g. itching, rash)?
- 21. Have diabetes?
- 22. Have asthma?

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> <input type="checkbox"/> | 23. Had mononucleosis in past 12 months?                                    | <input type="checkbox"/> <input type="checkbox"/> | 28. Wear or have any type of prosthetic device?  |
| <input type="checkbox"/> <input type="checkbox"/> | 24. Had problems with diarrhea/constipation?                                | <input type="checkbox"/> <input type="checkbox"/> | 29. Have any other condition that may require emergency or special care or medication? |
| <input type="checkbox"/> <input type="checkbox"/> | 25. Ever had an eating disorder?  | <input type="checkbox"/> <input type="checkbox"/> | 30. Ever been diagnosed with ADD or ADHD?  |
| <input type="checkbox"/> <input type="checkbox"/> | 26. If female, have an abnormal menstrual history?                          |   |  |
| <input type="checkbox"/> <input type="checkbox"/> | 27. Ever had emotional difficulties for which professional help was sought? |   |  |

Please explain any “yes” answers, noting the number of the questions.

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It is necessary for Mill Road Day Camp to have **parental permission for the dispensing of non-prescription medications to campers**. Below is a list of the possible non-prescription medications that can be administered by the Mill Road Health Staff. Please check off yes or no for each of the items listed. Your signature below indicates your permission for those items checked yes.

Ointments and Topical Antiseptics

YES NO

- 1. Solarcaine Spray or First Aid Cream
- 2. Sun block # 15 or Higher
- 3. Zinc Oxide
- 4. Hydrocortisone Cream
- 5. Eye Wash
- 6. Caladryl or Calamine Lotion
- 7. Sting Relief
- 8. Bacitracin
- 9. Neosporin

Items Ingested By Mouth

YES NO

- 1. Benadryl
- 2. Pepto-Bismol
- 3. \*Ipecac (only administered in emergency situation)
- 4. Robitussin
- 5. Sucrets
- 6. Midol
- 7. Tylenol
- 8. Advil
- 9. Tums
- 10. Sudafed
- 11. Roloids
- 12. Dimetapp
- 13. Mylanta

Parent Signature:



Which of the following has the camper had?

- Measles
- Chicken Pox
- German Measles
- Mumps
- Hepatitis

\_\_\_\_\_ Date of last TB Mantoux Test  
Result \_\_\_\_\_

Please give date of last immunization for.

Date	Vaccine
_____	DTP
_____	TD (tetanus/diphtheria)
_____	Tetanus
_____	Polio
_____	Hepatitis B
_____	MMR
_____	Measles ( hard or red measles or rubeola)
_____	Rubella
_____	HIB (Hepophilus Influenza B)
_____	Varicella Zoster

Has the camper been exposed to any communicable disease(s) within the past four (4) weeks? If yes, please specify \_\_\_\_\_

Doctor's Name (Print) \_\_\_\_\_

Street Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Telephone number ( ) \_\_\_\_\_