Camp Fairyland Health Record and Release Form

All Camps located in New York State required this form to be completed and signed **by a physician** and **parent** before the child can participate in Camp's activities. Every camper must bring this completed Form to camp check-in or before.

(Note: Please attach a copy of child medical insurance card)

PART A.

Child name: _____
Last First M.I.

DOB: _____ Age: _____ Sex: _____

SSN # _____

Parent/Guardian: _____
Address: _____
Phone (Home):_____
Phone (Cell):_____
Emergency Contact: _____
Phone: _____

Health Insurance Provider: _____
Policy name/ID Number_____
Policy Holder's Name & DOB_____
Insurance Provider Contact Phone_____

Parent's Authorization

My child may participate in all activities of Camp Fairyland.
I authorize emergency response personnel treat my child in case of emergency and Camp Fairyland authorized staff to administer any first aid to my child as they deem necessary in case of emergency and bring the child to the emergency room for treatment.
I understand that every attempt will be made to contact me, or the emergency contact, before taking this action.
I will be financially responsible for all emergency medical services provided to my child during camp and thereafter as needed.

Parent Signature_____ Date_____

****Note**** All medication will be checked and kept by the camp health officer. Only prescription medication can be sent to the camp to be administered at the camp. All prescription medication must be in the original pharmacy container labeled with the child's name, the name of the drug, and instructions for administration. It is illegal for our health office to dispense medication from improperly labeled containers.

Health History

Asthma: Yes/No
Diabetes: Yes/No
Heart Problem: Yes/No
Mono: Yes/No
Cancer: Yes/No
Ear Infection: Yes/No
Loss of Limb: Yes/No
Orthopedic Problem: Yes/No
Depression: Yes/No
Head Injury: Yes/No
Migraine: Yes/No
Tuberculosis: Yes/No

Other serious illness or injury: _____
Please explain all "yes" answers_____
_____
List all current medications (Prescription, "over the counter" and herbal) _____

PART B.

Health examination by licensed physician

Examination is acceptable when performed no more than 6 month prior to arrival to camp.

Immunization History (Please List Dates)

Copy of Immunization Record preferable

DPT_____ Booster_____
Polio OPV (Sabin) _____ Booster_____
Measles/Mumps/Rubella (MMR) #1_____ #2_____
Meningitis_____ See form, Td_____
Tuberculin Test _____ Results_____
Hepatitis B #1_____ #2_____ #3_____
Varicella _____
HIB #1_____ #2_____ #3_____

Child has had the meningococcal meningitis immunization (Menomune™) within the past 10 years.
Date Received _____

The applicant is under the care of physician for following condition(s): _____
_____
Restrictions/limitations for camper while at camp? Yes/No
If yes, please explain: _____
_____

Current treatment (include current medications): _____

Does applicant have epilepsy? Yes _____ No _____

Does applicant have diabetes? Yes _____ No _____

Any treatment to be continued at camp: _____
_____

Any medication to be administered at camp (specific dosages): ___
_____

Any medically prescribed meal plan or dietary restrictions: _____
_____

Any allergies (food, drugs, plants & insects, etc.): _____
_____

I have examined the person mentioned above, reviewed his/her health history and it is my opinion that he/she is physically able to participate in camp activities, except as noted above.

Physician's Name: _____
Address: _____
Phone: _____

Physician's Signature: _____

Date of Examination: _____