Philipstown Recreation Department

REQUIRED MEDICAL HISTORY

Please attach physician's physical form (including immunizations) from within the last year.

Name _____ Date of Birth: _____

Address _____ Phone#: _____

Emergency Notification:

Parent 1

Name_____Home_____Work_____Cell_____

Parent 2

Name_____Home_____Work_____Cell_____

Person to contact in an emergency if parents are unavailable:

Name_____Home_____Work_____Cell_____

Physician:_____Phone_____

Dentist/Orthodontist:_____Phone_____

Sunscreen

My child has permission to carry and use FDA approved sunscreen, for the purpose of protection from the sun. I understand sunscreen can not be applied by camp staff: Yes _____ No _____

Emergency Medical Information (check yes or no)

Yes___ No___ Seizure Disorder Yes___ No___ Diabetes Yes___ No___ Heart Trouble

Yes___ No___ Bleeding Disorder Yes___ No___ Asthma Yes___ No___ Dentures

Yes___ No___ Contact Lenses Yes___ No___ Bonded Teeth

Yes___ No___ Any condition that requires special care, medication or diet

Explain any of the above: _____

Has this person had Chicken Pox? ( ) Yes ( ) No If yes, when? Date _____

Has this person had Mumps? ( ) Yes ( ) No If yes, when? Date _____

Has this person been exposed to a contagious disease within the past three weeks? _____

Does this person take any medication on a regular basis? Yes _____ No _____

Explain: _____

Emergency Medications

(Please note– All emergency medication requires a physician's written order. All medications must be in pharmacy prepared containers and labeled with the name of the child, name of the drug, strength, dose, frequency, physicians name and date of the original prescription)

Does this person require: Epi-pen: yes no PRN Inhaler: yes no

This person has permission to carry: Epi-pen: yes no PRN Inhaler: yes no

To the best of my knowledge, the above information is correct. I give my child permission to participate in all camp activities and trips. In the event of accident or illness, I authorize the Camp to institute and obtain medical care. ** In the event of a communicable disease outbreak, I understand this person will be excluded from camp if not fully immunized.

DATE _____ SIGNATURE (parent or legal guardian) _____