CAMP BRIAR HILL

PERSONAL HEALTH AND MEDICAL RECORD

NOTE: This form does NOT need to be signed by a doctor.

Camper Information

Camper Name________ Date of Birth________

Address________ Age________ Sex________

City________ State________ Zip________

Parent Information

Mom's Name________ Cellular Phone________

Home Phone________ Work Phone________

Dad's Name________ Cellular Phone________

Home Phone________ Work Phone________

Emergency Contacts – if camp cannot reach parents

Name________ Relationship________

Address________ Home Phone________

City & State________ Cellular Phone________

Name________ Relationship________

Address________ Home Phone________

City & State________ Cellular Phone________

Physician Information

Name________ Office Phone________

Address________ City________ State________ Zip________

Medical Information

Has or is subject to (check and give details):

- ☐ Asthma
- ☐ Convulsions
- ☐ Heart Trouble
- ☐ Diabetes
- ☐ Fainting Spells
- ☐ High Blood Pressure
- ☐ Contact lenses
- ☐ Allergy or any reaction to any medicine, food, plant, animal, or insect toxin
- ☐ Any other condition that may require emergency or special care, medication or knowledge

Explain: ________

Participation Restrictions

Please check if child cannot fully participate in any of the following activities:

- ☐ Pool or water activities
- ☐ Sports or physical play (gymnastics, karate, etc.)
- ☐ Arts & Crafts
- ☐ Other ________

Explain: ________

Medical History

Date of most recent physical exam (month and year) ______________________________

Does camper have any current health problems? ☐ Yes ☐ No

Is camper currently under medical care or taking any medicines? ☐ Yes ☐ No

Has there been any surgery, injury, illness, allergy or change in health status since last complete physical exam? ☐ Yes ☐ No

Does camper have any special needs that may require additional accommodations? ☐ Yes ☐ No

Please explain any "Yes" answers:______________________________

____

Behavior Concerns

Does camper have any emotional, neurological, physical, or psychiatric disorders that affect his or her behavior? ☐ Yes ☐ No

Has the camper been evaluated for behavioral reasons or have a behavior related Individualized Education Program (IEP) or 504 plan? ☐ Yes ☐ No

At any time of the year, does camper take medication to help with behavior? ☐ Yes ☐ No

Please explain any "Yes" answers:______________________________

____

Immunizations – either fill out or attach doctor's record, dates are required

	Vaccinated	Date(s) Given	Still Needs	Has Had Disease
Diphtheria	☐	________	☐	☐
Whooping Cough	☐	________	☐	☐
Tetanus	☐	________	☐	☐
Polio	☐	________	☐	☐
Measles	☐	________	☐	☐
Mumps	☐	________	☐	☐
Rubella	☐	________	☐	☐
Chicken Pox	☐	________	☐	☐

The state of New Jersey requires all campers to meet school requirements for immunizations or present a medical or religious exemption. Please fill out the above information from doctor's medical history or provide exemption requests.

Disease history

	No	Yes	Year	Details
Serious Illness	☐	☐	____	________
Serious Injury	☐	☐	____	________
Surgery	☐	☐	____	________
Skin, Glands	☐	☐	____	________
Ears, Eyes	☐	☐	____	________
Nose, Sinus	☐	☐	____	________
Teeth, Dental	☐	☐	____	________
Chest, Lungs	☐	☐	____	________

	No	Yes	Year	Details
Heart	☐	☐	____	________
Rheumatic Fever	☐	☐	____	________
Stomach, Bowels	☐	☐	____	________
Appendicitis	☐	☐	____	________
Kidneys	☐	☐	____	________
Urine Infection	☐	☐	____	________
Back, Limbs, Joints	☐	☐	____	________
Other *(explain)*	☐	☐	____	________

Parent's Authorization

To the best of my knowledge, this history is correct and complete. I know of no reason to restrict my child's activity and give my permission for participation in all activities, except as specifically noted herein. In case of accident or serious illness, I request the camp to contact me. I authorize the camp to call the physician indicated above and to follow his instructions, and to seek any emergency care that the camp health director considers necessary.

Signature of parent or guardian: ______________________________