



**Camp Duffield Health History and Registration Form 2012
Parent/Guardian/Staff Form**

This will assist the Camp Medical Staff give appropriate care, so changes should be provided to the Camp Nurse upon arrival.

Name of Camper/Staff: Last _____ First _____

Home Address: _____
Street City State Zip

Home Phone# _____ Sex _____ Date of Birth: ____/____/____ Grade Completed _____

Parents/Guardians: _____
Custodial Parent Names

Parents Phone# Mom: _____ Dad: _____

Emergency Contact Information: (If unable to reach a parent, someone who is available 24/7)

1st contact name _____ Phone: _____ Relationship _____

2nd contact name _____ Phone: _____ Relationship _____

Health Insurance Company: _____

Name of Insured: _____ Relationship to participant: _____

ID #: _____ Group No: _____

A photocopy of the insurance card is required with this form.

Campers Physician: _____ Phone _____

Physicians Address: _____
Street City State Zip

Campers Dentist/Orthodontist _____ Phone _____

Parent/Guardian Authorizations: This health history is correct and complete to the best of my knowledge, and the person herein described has permission to engage in all camp activities except as noted on this form. I hereby give permission to the medical personnel selected by the Camp Director to secure proper treatment and transportation, for my child named above if deemed necessary. I also give permission to share their medical information for this purpose.

Signature of parent or guardian or adult camper/staff

Date

Print name
(This must be signed for camper to attend camp)



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This will assist the Camp Medical Staff give appropriate care, so changes should be provided to the Camp Nurse upon arrival.

Name of Camper/Staff: _____
Has camper/staff traveled outside the country in the past 9 months? _____
Where _____

General Questions: Explain yes answers below:

- 1. Had recent injury, illness or infectious disease? Yes No
- 2. Have a chronic or recurring illness/condition? Yes No
- 3. Ever been hospitalized or had surgery? Yes No
- 4. Have frequent headaches? Yes No
- 5. Ever had a head injury or been knocked unconscious? Yes No
- 6. Wear glasses or contacts Yes No
- 7. Ever had frequent ear infections? Yes No
- 8. Ever pass out or been dizzy during or after exercise? Yes No
- 9. Ever had seizures or convulsions? Yes No
- 10. Ever had chest pains during or after exercise? Yes No
- 11. Ever had high blood pressure? Yes No
- 12. Ever been diagnosed with a heart murmur or heart condition? Yes No
- 13. Ever had back problems? Yes No
- 14. Ever had joint problems? Yes No
- 15. Bringing an orthopedic device to camp? Yes No
- 16. Have any skin problems? Yes No
- 17. Have diabetes? Yes No
- 18. Have asthma? Yes No
- 19. Had mononucleosis in past 12 months? Yes No
- 20. Had problems with diarrhea/constipation? Yes No
- 21. Problems with sleepwalking or bed wetting? Yes No
- 22. If female – abnormal menstrual history? Yes No
- 23. Ever had a emotional problems for which professional help sought? Yes No
- 24. Ever had an eating disorder? Yes No
- 25. Bee sting reactions? Yes No
- 26. Hay fever or other allergies? Yes No
- 27. Wear glasses or contacts? Yes No

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Signature of parent or guardian or adult camper/staff

Date

Print name
(This must be signed for camper to attend camp)



**Camp Duffield Health History and Registration Form 2012
Physician's Report for 2012 Camp Season**

Name of Camper/Staff: _____
Date of physical: ____/____/____ (campers must be within one year of attending camp)

Has camper been hospitalized within the past 3 years? _____
If yes explain details and dates: _____

Patient's HT ____ WT ____ P ____ BP ____ RR ____

PHYSICAL EXAMINATION

SYSTEM	WITHIN NORMAL LIMITS	ABNORMAL	REASON
HEAD, NECK			
EARS, NOSE, THROAT			
LUNGS			
HEART			
ABDOMEN			
GENITALIA			
SPINE			
EXTREMITIES			
NEURO			
SKIN			
EYES			

MEDICATIONS

Please list all medications (including over the counter or non prescription drugs) being taken. Bring enough medication to last the entire time at camp. Keep in original packaging/bottle that identifies the medication, the prescribing doctor (if prescription drug), the dosage and frequency of administration.

MEDICATION	DOSAGE	TIMES GIVEN	REASON	SPECIAL INSTRUCTIONS

Signature of Physician _____ **Date** _____
Print Name or stamp _____



**Camp Duffield Health History and Registration Form 2012
Physician's Report for 2012 Camp Season**

Name of Camper/Staff: _____
Date of physical: ____/____/____ (campers must be within one year of attending camp)

Immunization History: Provide the **month and year for each immunization**. All immunizations must be current. Copies of immunization forms from health-care providers are acceptable; please attach to this form.

Immunization	Dose 1,	Dose 2,	Dose 3,	Dose 4,	Dose 5
DTaP or TdaP					
DT or TdaP					
MMR					
IVP					
HIB					
PCV					
Hepatitis A					
Hepatitis B					
Varicella					
Meningococcal					
Influenza					

Tuberculosis (TB) test Date: ____/____/____ **circle one: Negative Positive**
If positive please explain. _____

Allergy Information: _____ Does not apply (no allergies)

Allergy to:	Reaction:	Treatment:
Dust/Mold		
Insect Bites:		
Animals:		
Latex		
Sunscreen		
Food:		
Food:		
Medications:		
Medication:		

(Must bring epi pen, bee sting kit, lactose free milk if appropriate.)

Signature of Physician _____ **Date** _____

Print Name or stamp _____



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Physician's Report for 2012 Camp Season**

Name of Camper/Staff: _____
Date of physical: ____/____/____ (campers must be within one year of attending camp)

OVER THE COUNTER MEDICATION FORM

Your medical doctor must complete this form

I hereby authorize that the following medications may be given to the above named camper at Camp Duffield after nursing assessment.

Bactine (topical) for minor wound care, first aid as needed

Triple Antibiotic Ointment (topical) for wound healing

Tylenol (oral) as directed on bottle

Ibuprophen (oral) as directed on bottle

Cough Drops for coughing, minor throat irritation as needed

Antacid Tablet (oral) for stomach discomfort

Benydryl (oral or topical) for swelling, hives, allergic reaction as directed on bottle

Calamine Lotion or Cortaid (topical) for insect bites/bee stings

Visine/ Murine Plus Eye Drops (topical in eye) for minor eye irritation

Other (please describe) _____

"ALL PAGES OF PHYSICAL FORM NEED DOCTORS SIGNATURE."

Return all 5 forms to: Camp Duffield, 6 Lenox Ave., Lancaster, NY, 14086

PHYSICIAN CONSENT

Physician Signature _____ **Date** _____

Printed Name _____ **License Number** _____

Address _____ **Phone** _____

City _____ **State** _____ **Zip** _____ **Fax** _____