

TOWN OF HUNTINGTON

Project P.L.A.Y./St. John's Camp 2015

GENERAL MEDICAL & HEALTH INSURANCE & EMERGENCY FORM

(PLEASE PRINT)

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Sex: \_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_  
Street Town Zip

Mother's Business # \_\_\_\_\_ Father's Business #: \_\_\_\_\_

Mother's Cell Phone # \_\_\_\_\_ Father's Cell Phone #: \_\_\_\_\_

\*\*IF PARENTS CANNOT BE REACHED-EMERGENCY NUMBERS:

1. Name: \_\_\_\_\_ Phone # \_\_\_\_\_  
(area code)

2. Name: \_\_\_\_\_ Phone # \_\_\_\_\_  
(area code)

HEALTH INSURANCE INFORMATION

CARRIER OR PLAN NAME \_\_\_\_\_ GROUP # \_\_\_\_\_  
NAME OF INSURED \_\_\_\_\_ RELATIONSHIP TO PARTICIPANT \_\_\_\_\_  
INSURANCE ID # \_\_\_\_\_

***NOTE:*** All medication(s) sent to camp ***MUST*** be labeled by pharmacy. We cannot administer medication.

**ALL MEDICATIONS ARE SELF-ADMINISTERED BY THE CHILD.**

**In the event that I cannot be reached by phone, I give my permission to the Camp Director or their appointed representatives to act in my behalf in seeking and providing medical treatment for my child during the camp season. This includes medical care and treatment by a first aid station or physician in a hospital.**

Signature of Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_

TOWN OF HUNTINGTON

# Project P.L.A.Y./St. John's Camp 2015

TO BE COMPLETED BY A MEDICAL DOCTOR

## IMMUNIZATION HISTORY FORM

(Show dates of last immunization or booster)

IF CHILD BORN AFTER JANUARY 1, 1993 – MUST FILL IN DATES OF HEPATITIS B: \_\_\_\_\_

HAEMOPHILUS INFLUENZA TYPE B: \_\_\_\_\_

MEASLES \_\_\_\_\_ MUMPS \_\_\_\_\_ HIB \_\_\_\_\_

RUBELLA \_\_\_\_\_ DPT \_\_\_\_\_

POLIO SALK/SABIN \_\_\_\_\_ MMR \_\_\_\_\_

VARICELLA (Chicken Pox) \_\_\_\_\_

TBC: Date \_\_\_\_\_ Results \_\_\_\_\_

\_\_\_\_\_ is in good health, is not suffering from any illness and  
(name of camper)

May \_\_\_\_\_ May Not \_\_\_\_\_ participate in a full program of activities.

### DIETARY/PHYSICAL

RESTRICTIONS: \_\_\_\_\_

I have prescribed the following medication for \_\_\_\_\_, **which is self-administered**

1. Name of medications: \_\_\_\_\_
2. Dosage: \_\_\_\_\_
3. Purpose of medications: \_\_\_\_\_

**ALL MEDICATIONS ARE SELF-ADMINISTERED BY CHILD AND MUST BE LABELED BY PHARMACY**

SIGNATURE OF PHYSICIAN: \_\_\_\_\_

PHYSICIAN'S NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE # \_\_\_\_\_

DATE: \_\_\_\_\_

This form must be submitted to the Town of Huntington in order for a child to participate in the camp program.

TOWN OF HUNTINGTON  
**Project P.L.A.Y./St. John's Camp 2015**

**GENERAL MEDICAL HISTORY FORM**

**LAST NAME :** \_\_\_\_\_ **FIRST NAME :** \_\_\_\_\_

PLEASE TAKE THE NEXT FEW MINUTES TO ANSWER THE FOLLOWING QUESTIONS. REMEMBER: YOUR CHILD'S SAFETY AND HEALTH IS IMPORTANT TO US. PLEASE BE HONEST IN YOUR RESPONSES SO WE CAN DO EVERYTHING WITHIN OUR ABILITIES TO INSURE THAT YOUR CHILD HAS A GREAT TIME AT THIS SUMMER PROGRAM. IF YOU HAVE ANY QUESTIONS CONCERNING THE INFORMATION ON THIS FORM, PLEASE DO NOT HESITATE TO ASK US.

**HAS YOUR CHILD EVER HAD OR DO THEY NOW HAVE: Please check one**

	YES	NO
(1) Asthma, wheezing, or inhaler use		
(2) Epilepsy, fits, seizures, or convulsions		
(3) Recurrent neck or back pain		
(4) Rheumatic fever		
(5) Dislocated joint, knee, hip, shoulder, elbow or ankle		
(6) Foot pain		
(7) Periods of unconsciousness		
(8) Frequent or severe headaches causing interruptions in school		
(9) Wear contact lenses		
(10) Fainting spells or passing out		
(11) Head injury, skull fracture, concussion		
(12) Seen a psychiatrist, psychologist, counselor or social worker		
(13) Skin disorders such as: Eczema Psoriasis Atopic Dermatitis		
(14) Irregular heartbeat, rapid or slow heartbeat		
(15) Thyroid condition or taking medication for thyroid		
(16) Limitation on movement or motion of joint, wrist, knee, hip, shoulder		
(17) Heart murmur, heart abnormality or problems		
(18) Heart surgery		
(19) High blood pressure		
(20) Hepatitis (liver inflammation or infection)		
(21) Any eye injury or surgery (other than corrective)		

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## GENERAL MEDICAL HISTORY FORM - Continued

	Please check one	
	YES	NO
(22) Allergies: Common foods (milk, peanuts, eggs, meat, fish, etc.) Wool or fabrics Wasp, bee or any insect stings Penicillin Poison ivy Drugs (prescription or medication) Other: please specify _____		
(23) Broken bones requiring surgery to repair		
(24) Perforated ear drum or tubes in ear drums		
(25) Anemia (iron deficiency)		
(26) Pain or swelling at the site of an old fracture		
(27) Loss of appendage, limb or part thereof		
(28) Attention Deficit Disorder		
(29) Diseases: Chicken pox German measles Mumps Tuberculosis Measles Other: please specify _____		
(30) If the answer to any of the above is "Yes" please reference the question number then Describe or explain with dates:		

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