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:_____

_____

- continued on back -

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

	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 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: _____