



Brimmer and May School Summer Camp
 69 Middlesex Road, Chestnut Hill, MA 02467
Camper Health History and Information Form

The information on this form is confidential and will not be released without consent from parent/guardian.

Camper Name _____ Date Of Birth ____ / ____ / ____

Home Phone _____

Parent/ Guardian Name _____

Cell Phone _____ Work/Other Phone _____

Parent/ Guardian Name _____

Cell Phone _____ Work/Other Phone _____

Additional Emergency Contact _____ Relationship _____

Cell Phone _____ Work/Other Phone _____

Camper's Primary Care Provider _____ Phone _____

INSURANCE INFORMATION: Is the camper covered by insurance? Yes _____ No _____

If **yes**, please include a copy of the front and back of their insurance card for each camper.

Insurance Company name _____

Does the student have any **ALLERGIES (food, medication, environmental, etc)**? Yes _____ No _____

Does the student carry an **Epinephrine Auto-injector (EpiPen)**? Yes _____ No _____

Note: Campers who carry EpiPens will need to provide prescriber orders and bring TWO to camp

| Allergy Trigger | Typical Reaction | Treatment |
|-----------------|------------------|-----------|
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Does you camper take **SCHEDULED and/or AS NEEDED MEDICATION**? Yes _____ No _____

Note: Campers who need to take medication during the camp day will need prescriber orders

| Medication (Name, Dose, Times) | Reason for Taking | Will they need to take this at camp? |
|--------------------------------|-------------------|--------------------------------------|
| | | Yes _____ No _____ |
| | | Yes _____ No _____ |
| | | Yes _____ No _____ |
| | | Yes _____ No _____ |

STUDENT MEDICAL HISTORY and INFORMATION

| Previous/ Current Medical Concerns | Yes | No | Comments: Treatment and Approximate Dates |
|------------------------------------|-----|----|---|
| Cardiac Disorder | | | |
| Seizures/ Neurological Disorder | | | |
| Diabetes/ Metabolic Disorder | | | |
| Bleeding Disorder | | | |
| Hospitalization/ Surgery | | | |
| Asthma/ Respiratory Disorder | | | |
| Chronic Illness | | | |
| Visual Deficit/ Eye Disorder | | | |
| Speech Deficit/ Throat Disorder | | | |
| Diet Restrictions, Digestive Dis. | | | |
| Orthopedic Disorder | | | |
| Menstrual/ Genitourinary Dis. | | | |
| Chicken Pox | | | |
| Mononucleosis | | | |
| Other that may impact camp day | | | |
| Psycho/Social Concerns | | | |
| ADD/ADHD | | | |
| Other Psychological diagnoses | | | |
| Camp Concerns | | | |
| Restrictions to Activities | | | |
| Accommodations Needed | | | |
| Other comments or concerns | | | |

The Camp health office has a small supply of over-the-counter medicines including: Acetaminophen (Tylenol), Ibuprofen (Advil/Motrin), Antibiotic Ointment, Calamine Lotion, Diphenhydramine (Benadryl), Hydrocortisone Cream, and Calcium Carbonate (Tums). Please indicate your preference.

Do you authorize this? Yes _____ No _____

If **No**, please specify what you would like withheld _____

We require that all children wear sunscreen while at camp. We ask that parents provide sunscreen which can be applied throughout the day, by your child's counselor at your request. Please indicate your preference. **Do you**

authorize this? Yes _____ No _____

If **No**, please specify how your camper will have sunscreen applied _____

As the parent/legal guardian of this camper, I have answered these questions honestly and to the best of my knowledge. I understand that any withheld or falsified information could be damaging to my campers' health and could lead to withdrawal from the Brimmer and May School summer program.

Signature _____ **Date** _____