NEW HORIZONS DAY CAMP - PERSONAL HEALTH & MEDICAL RECORD

Assistant Counselors: *Parents may complete.* ***Counselors:*** *You may complete.*

PO Box 536
Livingston, NJ 07039
(973) 850-6640

Name _____ Date of Birth _____

Address _____ Age _____

City & State _____ Sex _____

IN CASE OF AN EMERGENCY NOTIFY:

1. Name _____ Relationship _____ ___ Home # _____ ___ Business # _____

2. Name _____ Relationship _____ ___ Home # _____ ___ Business # _____

EMERGENCY MEDICAL INFORMATION:

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

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

Explain _____

_____

APPROVED FOR PARTICIPATION IN:

- ☐ Hiking and Camping
- ☐ Water Activities
- ☐ Competitive Sports
- ☐ All Activities

Recommendations: (Explain any restrictions/limitations)

_____

_____

_____

_____

_____

_____

IMMUNIZATIONS:

	Month/Year Given	Needed
Tetanus	_____	☐
Diphtheria	_____	☐
Polio	_____	☐
_____	_____	☐
_____	_____	☐

HAS HAD:	Vaccine	Disease	Needed
Measles	☐	☐	☐
Mumps	☐	☐	☐
Rubella	☐	☐	☐
Whooping Cough	☐	☐	☐
Chicken Pox	☐	☐	☐

MEDICAL HISTORY

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

Are there any recurrent health problems? ☐ No ☐ Yes

Now under medical care or taking any medicines? ☐ No ☐ Yes

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

_____

(Explain any "yes" answers in space below)

_____

_____

Is there disease of (or past or present history of):

	No	Yes	Year	Details
Serious Illness	☐	☐	_____	_____
Serious Injury	☐	☐	_____	_____
Deformity	☐	☐	_____	_____
Surgery	☐	☐	_____	_____
Skin, Glands	☐	☐	_____	_____
Ears, Eyes	☐	☐	_____	_____
Nose, Sinus	☐	☐	_____	_____
Teeth, Tonsils	☐	☐	_____	_____
Dentures	☐	☐	_____	_____
Bridge	☐	☐	_____	_____
Chest, Lungs	☐	☐	_____	_____
Heart	☐	☐	_____	_____
Murmur	☐	☐	_____	_____
Rheumatic Fever	☐	☐	_____	_____

	No	Yes	Year	Detail
Stomach, Bowels	☐	☐	_____	_____
Appendicitis	☐	☐	_____	_____
Kidneys or Urine	☐	☐	_____	_____
Infection	☐	☐	_____	_____
Bed-wetting	☐	☐	_____	_____
Menstrual Problems	☐	☐	_____	_____
Hernia Rupture	☐	☐	_____	_____
Backs, Limbs, Joints	☐	☐	_____	_____
Sleepwalking	☐	☐	_____	_____
Behavioral Condition	☐	☐	_____	_____
Other (explain)	☐	☐	_____	_____

Physician's name _____ Address _____ Phone # _____

PARENT'S AUTHORIZATION:

To the best of my knowledge, history is correct and complete. I know of no reason to restrict applicant's activity, and give my permission for participation in all activities except as specifically noted herein. In the event I cannot be reached in an EMERGENCY, I hereby give permission to the physicians selected by the camp director to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child as named above.

Parent or Guardian _____ Applicant's Signature if 18 + _____ Date _____