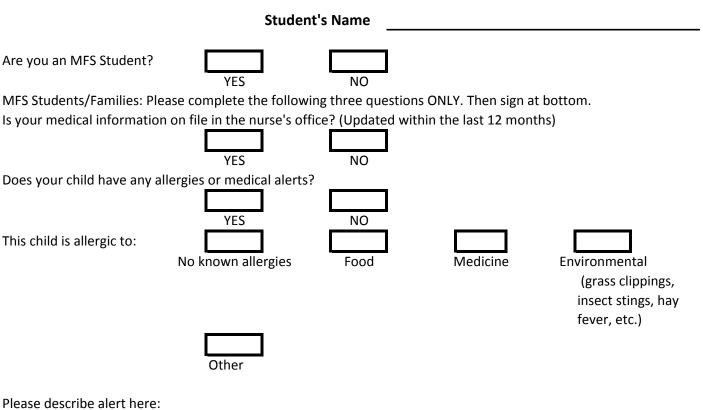




Moorestown Friends School

Camper Health Information - Summer 2019

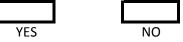
Today's Date



Medication:

"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins and natural remedies. Please send all medications in their original pharmacy containers with labels which show the camper's name and how the medication should be given. Provide enough of each medication to last the entire week.

Are you providing an EpiPen or prescription medication for your child?

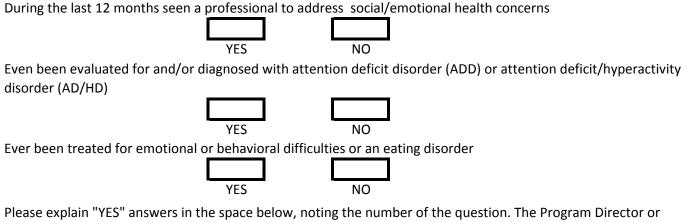


Social and Emotional Health: Check "YES" or "NO" for each statement.

Has the child:

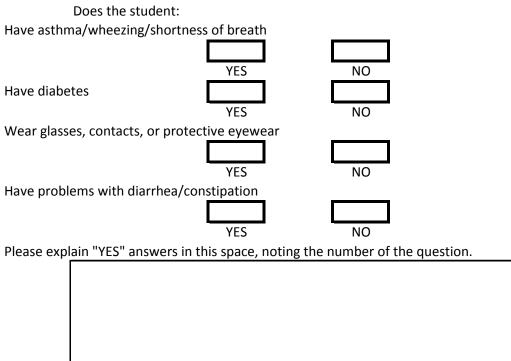
(turn to next page)

Student's Name



Nurse may contact you for additional information.

General Health History: Check "YES" or "NO" for each statement/ Explain "YES" answere below.



Restrictions:



I have reviewed the programs and activities of the camp and feel the child can participate WITHOUT restrictions.

Student's Name



Please describe here:

I have reviewed the programs and activities of the camp and feel the child can participate WITH THE FOLLOWING RESTRICTIONS or adaptations:

Immunization History:

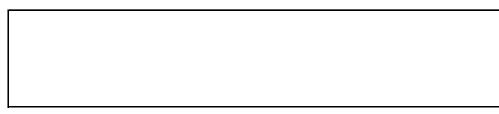
Provide the month and year for each immunization. Starred (*) immnuizations must be current. Copies of immunization forms from health care providers or state or local governments are acceptable. You may: fill in the fields below, FAX to 856-235-6684, email your scanned document to the program director, or upload your document into the online registration system (follow prompts in "Document Center").

Diptheria, tetanus, pertussis* (DTaP) or (TdaP)		
Doses in Month/Year		
Tetanus booster* (dT) or (TdaP)		
Most rcent Dose Month/Year		
Mumps, measles, rubella* (MMR)		
Doses in Month/Year		
Polio* (IPV)		
Doses in Month/Year		
Haemophilus influenza type B (HIB)		
Doses in Month/Year		
Pneumococcal (PCV)		
Doses in Month/Year		
Hepatitis B		
Doses in Month/Year		
Hepatitis A		
Doses in Month/Year		
Varicella (Chicken Pox)		
Doses in Month/Year		
Had chicken pox? Date?		
YES NO		
Meningococcal meningitis (MCV4)		
Doses in Month/Year		
Tuberculosis (TB) test		
Date?		
YES NO		
Student's Name		
TB test results		
Negative Positive		

If your camper has not been fully immunized for religious exemption reasons, please sign the following statement: <i>I understand and accept the risks to my child from not being fully immunized</i> .	
Signature of Custodial Parent/Guardian: Date:	
Relationship to Camper:	
Medical Insurance Information/Healthcare Providers	
This camper is covered by family medical/hospital insurance	e YES NO
Name of child's PCP	-
Phone #	

What have we forgotten to ask?

Please provide in the space below any additional information about the student's physical, social or emotional health that you feel is important or that may affect the child's ability to fully participate in the program.



Permission to 'Treat' Authorization

I hereby give permission to the medical personnel to provide routine healthcare; to administer prescribed medications; and to administer emergency treatment for me/my child, including, but not limited to X-rays, routine tests and treatment and/or hospitalization; and to provide or arrange necessary related transportation for me/my child. I also agree to the release of any records necessary for treatment, referral, billing or insurance purposes.

If the person named herin is a minor, it is my intention that representatives of the camp be considered 'personal representatives' for the purpose of disclosing health information that is protected under the Health Insurance Portability and Accountability Act of 1996. I also agree to the disclosure to camp representatives of protected health information of the person named herin in order to provide information related to the person's ability to participate in camp activities; and if the person named herin is a minor, to provide information to the camp representatives to keep me informed of my child's health situation.

In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for the named person. This completed form may be photocopied for trips out of camp.

Student's Name

Camper Agreement

I understand and agree to abide by any restrictions placed on my activity at MFS Summer Programs.

Camper Initials _____ Today's Date:

Completion Acknowledgement

Yes, this information is complete and accurate.

Parent/Guardian Signature Required