

CHAMBERS WESLEYAN CAMP – CAMP HEALTH FORM 2008

To be completed by all campers, staff members & children of staff members under the age of 26 - LEAVE NO BLANKS!

Name: _____ Birth Date: _____ Age: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Health Ins. Co.: _____ Member/ID No.: _____ Group No.: _____
 Parent/Guardian/Spouse: _____
 Home Phone: () _____ Work Phone: () _____ Cell Phone: () _____
 Emergency Contact (Not listed above.): _____ Telephone: () _____

EXTREMELY IMPORTANT: Chambers Wesleyan Camp requires that each person under the age of 26 **MUST** have the following immunization history filled in as completely as possible, and it **must be signed** by a health professional, school nurse or family physician **OR** a copy of a completed certified health facility's shot record may be attached to this form.

The dates of all immunizations, including all series must be clearly shown. Failure to comply with this requirement will cause your registration, or application to work, to be returned. You may be charged a late fee, or be unable to work.

Your tetanus booster needs to be completed **prior** to the camp if you are not currently within the 10 year boundary of having acceptable tetanus protection. When calculating your protection boundary include the finish date of the latest camp in which you are participating. If you are unsure you are within the acceptable boundaries get the booster shot.

No over-the-counter medications will be allowed without a signed note from a doctor.

All dates of shot series must be listed – not just the date completed.

Date of Birth: ____ / ____ / ____
Month Day Year

IMMUNIZATION HISTORY	DATE	DATE	DATE	DATE	DATE
DTP (Diphtheria / Tetanus / Pertussis)					
DT (Diphtheria / Tetanus)					
Hib (Haemophilus Influenzae Type B)					
IPV (Inactivated Poliovirus Vaccine)					
OPV (Oral Poliovirus Vaccine)					
PCV (Pneumococcal Conjugate Vaccine)					
HPV (Hepatitis B)					
MMR (Measles / Mumps / Rubella - Ger Measles)					
MR (Measles / Rubella - German Measles)					
V (Varicella - Chicken Pox)					
Td (Tetanus-Diphtheria Booster)					
Flu (Influenza Vaccine)					
Rabies					

REQUIRED: _____

Signature of School Nurse or Physician
Title
Date

DO NOT COPY THIS HEALTH FORM ONTO THE BACK OF ANY OTHER FORMS
KEEP THE HEALTH FORM PAGES SEPARATE!

Camper / Staff Name: _____ Birth Date: _____ Age: _____

PLEASE COMPLETE THESE QUESTIONS AND LEAVE NO BLANK SPACES!

1. Does this camper/staff take any medications regularly or occasionally? YES NO **If yes, list medications & why.**

MEDICATIONS NOTES: 1. All medications, including non-prescription medications, coming to camp must be in the original containers and correctly labeled. 2. Doctor's orders via a doctor's note are required for prescription sample packets and over the counter medications. These are NY State requirements that must be followed.

2. Is this camper/staff allergic to any medications? YES NO **If yes, please list.**

3. Does camper/staff have any other allergies (insect stings/bites, latex, foods, etc.)? YES NO **If yes, please list.**

4. Has this camper/staff been exposed to any communicable diseases recently? YES NO **If yes, what is the disease and, (if applicable), how recently were they exposed?**

5. Is there any reason this camper/staff should not participate in athletic activity, (hiking, swimming, softball, etc.)?
YES NO **If yes, please explain.**

6. Does camper/staff struggle with bedwetting? YES NO ; Sleepwalking? YES NO ; Night Terrors? YES NO

7. Are there existing medical needs or additional information our staff should be aware of concerning this camper/staff (such as any disability, prior operations, special precautions, seizures, emotional concerns, etc.)?
YES NO **If yes, please explain.**

MEDICALLY NECESSARY DIETARY NEEDS

If you or your child have any medically necessary dietary needs please fill out the additional MEDICAL DIET FORM.
THIS FORM MUST BE RECEIVED TWO WEEKS BEFORE THE START OF CAMP!

I hereby grant permission for my child/self to attend/work at Chambers Wesleyan Camp. In the event of an emergency, I hereby give my permission for him/her to receive any such medical treatment as is necessary for serious illness or injury, as administered by the camp health staff, and/or hospital.

Date: _____

Signature of parent/legal guardian, or self if over 18 – ***A Health Form without a signature will not be accepted!***

DO NOT COPY THIS HEALTH FORM ONTO THE BACK OF ANY OTHER FORMS

KEEP THE HEALTH FORM PAGES SEPARATE!