

THIS HEALTH FORM WILL BE RETURNED TO YOU UNLESS FILLED OUT **COMPLETELY** AND SIGNED BY PARENT.

Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_

Street \_\_\_\_\_ Town \_\_\_\_\_ Zip \_\_\_\_\_ Telephone(\_\_\_\_) \_\_\_\_\_

Father \_\_\_\_\_ Business Telephone (\_\_\_\_) \_\_\_\_\_

Mother \_\_\_\_\_ Business Telephone (\_\_\_\_) \_\_\_\_\_

**MUST BE COMPLETED.** 1. \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_

*If not available in case of illness or emergency notify:* 2. \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_

**Health History:**

Operations or serious injuries (*dates*) \_\_\_\_\_

*(Check Give approximate dates)*

Disability or chronic or recurring illness \_\_\_\_\_

- \_\_\_\_ Frequent Ear Infections
- \_\_\_\_ Heart Defect/Disease
- \_\_\_\_ Convulsions
- \_\_\_\_ Diabetes
- \_\_\_\_ Bleeding/Clotting
- \_\_\_\_ Disorders
- \_\_\_\_ Hypertension
- \_\_\_\_ Mononucleosis
- \_\_\_\_ Psychiatric Treatment
- \_\_\_\_ Epilepsy

Activities encouraged or limited by physician \_\_\_\_\_

Current medications (*send with instructions*) \_\_\_\_\_

Other diseases or details of above \_\_\_\_\_

Has this camper ever required any psychiatric counseling or hospitalization? \_\_\_\_\_

Explain \_\_\_\_\_

**Diseases**

- \_\_\_\_ Chicken Pox
- \_\_\_\_ Measles
- \_\_\_\_ German Measles
- \_\_\_\_ Mumps

Name of dentist/orthodontist \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Name of family physician \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Do you carry family medical/hospital insurance? \_\_\_\_ Yes \_\_\_\_ No

**Allergies** (*Date not required*)

- \_\_\_\_ Hay Fever
- \_\_\_\_ Poison Ivy
- \_\_\_\_ Asthma
- \_\_\_\_ Medications
- \_\_\_\_ Bee Sting
- \_\_\_\_ Peanuts
- \_\_\_\_ Other (Specify.) \_\_\_\_\_

Name of Insurance Co. \_\_\_\_\_ Policy or Group # \_\_\_\_\_

*(This form will be returned if you do not fill in the insurance company and policy or group number.)*

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted. Authorization for Treatment: I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, treatment and necessary transportation for me/or my child. In the event 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 my child as named above.

\_\_\_\_\_  
*Signature of parent or guardian or staff if over 18 yrs.*

\_\_\_\_\_  
*Date*

**MUST BE RETURNED BY APRIL30 TO: CAMP SEWATARO, ONE LIBERTY LEDGE, SUDBURY, MA 01776**

**(over)**

