

CAMP KENNYBROOK MEDICAL INFORMATION RECORD 2010

Camper's Name: _____ Sex: _____ Telephone: _____

Date of Birth: _____ Age: _____ Weight: _____ Height: _____ Soc. Sec.: _____

IMMUNIZATION RECORD

Please be sure to fill out all dates:
3 or more doses of DIPHTHERIA TOXOID _____
3 or more doses of ORAL POLIO VACCINE (OPV) _____
OR 4 or more POLIO (IPV) _____
2 doses of MEASLES, MUMPS, RUBELLA VACCINE _____
Hepatitis B (7th grade and above) _____
LAST TETANUS BOOSTER _____
Varicella (chicken pox) _____
Haemophilus Influenza Type B _____
HeHepatitis B _____

ALLERGIES

Please list: MEDICATION, FOOD, INSECT BITES, ETC.

1. In the event of a POSITIVE THROAT CULTURE, I prescribe: _____

2. For PAIN or ANTIPYRETIC MEDICATION I prescribe: _____

WILL CAMPER BE BRINGING MEDICATION TO CAMP: Yes _____ No _____

ALL medications for every camper, including over the counter and prescription medications MUST be written on the PHYSICIANS ORDERS FORMS.

.....
I have examined the above named camper and find this child to be physically able to enter into all camp activities Yes _____ No _____

If NO, please list restriction: _____

Physician's Name: _____ (please print)

Address: _____

Telephone Number: _____

Physician's Signature _____

Physician's Stamp

TO BE COMPLETED BY PARENT

PHYSICAL HISTORY

(Please explain yes answers.)

HEART MURMUR: Yes No

ASTHMA: Yes No

ANY RECENT INJURY, ILLNESS, or INFECTIOUS DISEASE: Yes No

CHRONIC OR RECURRING ILLNESS/CONDITION: Yes No

HEADACHES: Yes No

BED WETTING: Yes No

ORTHOPEdic PROBLEMS: Yes No

WEAR GLASSES OR CONTACT LENSES: Yes, when _____ No

STOMACH PROBLEMS: Yes No

SLEEPING PROBLEMS: Yes No

SLEEPWALKING: Yes No

EMOTIONAL PROBLEMS: Yes No

Please note any comments pertaining to the physical or emotional well being of the camper that would be helpful to the medical staff:

DIETARY RESTRICTIONS

FOOD ALLERGIES: Please explain

Does not eat: Meat _____ Poultry _____ Dairy _____ Other _____

HAS YOUR CHILD EVER HAD:

CHICKEN POX: Yes _____ No _____ Date: _____

Head Lice: Yes _____ No _____ Date(s): _____

INSURANCE INFORMATION

FAMILY MEDICAL/HOSPITAL INSURANCE NAME: _____

GROUP NUMBER: _____

CARRIER ADDRESS: _____

NAME OF INSURED: _____

In the event of an emergency, Camp Kennybrook Inc., is authorized to have x-rays taken, administer medication, order routine tests, use medical and dental specialists and any care considered essential to the health and well being of my child.

Parent /Guardian Signature

Date

If parents cannot be contacted, please provide EMERGENCY NAME AND NUMBER
