

**CAMP KENNYBROOK MEDICAL INFORMATION RECORD**

**2008**

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

\_\_\_\_\_