

CAMP BRIAR HILL

PERSONAL HEALTH AND MEDICAL RECORD

NOTE: This form does NOT need to be signed by a doctor.

Camper Information

Camper Name _____ Date of Birth _____
Address _____ Age _____ Sex _____
City _____ State _____ Zip _____

Parent Information

Mom's Name _____ Cellular Phone _____
Home Phone _____ Work Phone _____
Dad's Name _____ Cellular Phone _____
Home Phone _____ Work Phone _____

Emergency Contacts – if camp cannot reach parents

Name _____ Relationship _____
Address _____ Home Phone _____
City & State _____ Cellular Phone _____
Name _____ Relationship _____
Address _____ Home Phone _____
City & State _____ Cellular Phone _____

Physician Information

Name _____ Office Phone _____
Address _____ City _____ State _____ Zip _____

Medical Information

Has or is subject to (check and give details):

- Asthma Convulsions Heart Trouble
 Diabetes Fainting Spells High Blood Pressure
 Contact lenses
 Allergy or any reaction to any medicine, food, plant, animal or insect toxin
 Any other condition that may require emergency or special care, medication or knowledge

Explain: _____

Participation Restrictions

Please check if child cannot fully participate in any of the following activities:

- Pool or water activities
 Sports or physical play (gymnastics, karate, etc.)
 Arts & Crafts
 Other _____

Explain: _____

- continued on back -

Medical History

Date of most recent physical exam (month and year) _____

Does camper have any current health problems? Yes No

Is camper currently under medical care or taking any medicines? Yes No

Has there been any surgery, injury, illness, allergy or change in health status since last complete physical exam? Yes No

Does camper have any special needs that may require additional accommodations? Yes No

Please explain any "Yes" answers: _____

Behavior Concerns

Does camper have any emotional, neurological, physical, or psychiatric disorders that affect his or her behavior? Yes No

Has the camper been evaluated for behavioral reasons or have a behavior related Individualized Education Program (IEP) or 504 plan? Yes No

At any time of the year, does camper take medication to help with behavior? Yes No

Please explain any "Yes" answers: _____

Immunizations

	Vaccinated	Date(s) Given	Still Needs	Has Had Disease
Diphtheria	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Whooping Cough	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Tetanus	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Polio	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Measles	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Mumps	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Rubella	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Chicken Pox	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>

The state of New Jersey requires all campers to meet school requirements for immunizations or present a medical or religious exemption. Please fill out the above from doctor's medical history or provide exemption requests.

Disease history

	No	Yes	Year	Details
Serious Illness	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Serious Injury	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Skin, Glands	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Ears, Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Nose, Sinus	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Teeth, Dental	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Chest, Lungs	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

	No	Yes	Year	Details
Heart	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Stomach, Bowels	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Appendicitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Kidneys	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Urine Infection	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Back, Limbs, Joints	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Other (explain)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

Parent's Authorization

To the best of my knowledge, this history is correct and complete. I know of no reason to restrict my child's activity and give my permission for participation in all activities, except as specifically noted herein. In case of accident or serious illness, I request the camp to contact me. I authorize the camp to call the physician indicated above and to follow his instructions, and to seek any emergency care that the camp health director considers necessary.

Signature of parent or guardian: _____