

CAMP TIOGA HEALTH FORM 2010

Mail to the address below by APRIL 1ST

Camp Tioga
1191 Old Country Road
Plainview, N.Y. 11803
516-938-0894 Fax-516-938-3184

Name _____ Birthdate _____ Sex _____ Age _____
Last First

Parent/Guardians: _____ Home # _____ Work # _____

Parent/Guardian: _____ Home # _____ Work # _____

Address: _____
Street and # City State Zip

Emergency #'s: _____ Emergency #'s _____
Cell phones Cell phones

Emergency #'s: _____ Emergency #'s _____
Family member/name and number Family member/name and number

HEALTH HISTORY (TO BE COMPLETED BY PARENT)

Allergies to food or medication: _____

Operations or serious injury: _____

Chronic or recurring illness or medical condition: _____

Daily Medications (must fill out additional forms): _____

As Needed Medications (must fill out additional forms): _____

Name of Physician _____ Phone _____ Dentist/Orthodontist _____ Phone _____

Insurance (**MUST ATTACH COPY OF CARDS**): Insured Name _____ DOB _____

Policy Number _____ Name of Insurance Co. _____ Group _____

Policy Holders Employer _____
Name Address Phone

For Females:

Has this person menstruated? _____ If not, has she been told about it? _____

Important: This box must be signed for attendance to camp.

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 on this form. **Authorization of Treatment:** I hereby give permission to the medical personnel selected by the camp director to order x-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary transportation for me/or my child. In the event that I cannot be reached in an emergency, I hereby give permission to the physicians selected by the camp director to secure and administer treatment including hospitalization, for the person named above. The completed forms may be photocopied for trips out of camp.

Signature of Parent/Guardian - _____ Witness _____ Date _____

I also understand and agree to abide with the restrictions placed on my camp activities. _____

Restricted Activities (Please List)

Signature of Minor or Adult Camper/Staff _____ Date _____

Immunization History

Required immunizations must be determined locally. Please record the date (month and year) of basic immunizations and most recent booster doses.

VACCINES	DATES	DIETARY RESTRICTION
Diphtheria Pertussis (whooping Cough) DPT Tetanus or	1 2 3	Can Not Eat (please check)
Tetanus Diphtheria TD or		RED MEAT _____
Tetanus		PORK _____
Oral Polio (Sabia) TOPV		SEAFOOD _____
Injectable Polio (Salk)		EGGS _____
Measels (hard measles, red measles, rubeola)		FRUIT _____
Mumps		WHEAT _____
Rubella (German Measles, 3-day measles)		NUTS _____
Other		OTHER _____
Tuberculin test given _____ (most recent)		
Haemophilus Influenza b (HIB)		
Hepatitis B		

Health Care Recommendations by Licensed Physician

I have examined the above camp applicant within the past year. Date examined _____

In my opinion, the above condition does does not preclude his/her participation in an active camp program.

Height _____ Weight _____ Blood Pressure _____

The applicant is under the care of a physician for the following condition(s)

Current treatment (include current medications and reasons for taking them) _____

Explanation of any reported loss of consciousness, convulsion or concussion _____

Has applicant ever had a seizure? yes no Does applicant have diabetes yes no

Recommendations and Restrictions While at Camp

Any treatment to be continued at camp _____

Any Medication to be administered at camp (specific dosage) _____

Any medically prescribed meal plan or dietary restrictions _____

Any allergies (food, drugs, plants, insects, etc) _____

Any history of: Dizziness _____ Heart Disease _____ Fainting _____ Orthopedic Problems _____

Eating Disorder _____ Psychological or Social Problems _____ Bedwetting _____

Additional Health Information _____

Licensed Physician's Signature - _____

Address _____ **Phone** _____

Date of Form Completion _____ **BY** _____

Initial if completed by nurse of physician's assistant