EWING RECREATION SUMMER CAMP 2016

This Health History Record must be completed and returned to the camp office before a camper is allowed to attend camp. **Children are NOT allowed to attend camp until all required health information has been submitted to the Ewing Recreation Office.** If this camper has a physical exam within the past year a new exam is not required. Please complete this form and attach a copy of your child's most recent physical exam. If your child has not had a physical exam in the past year please make an appointment with your child's physician to conduct an examination and complete Section 2 of this form. Whether or not your child requires a new exam, your child's physician must sign Section 2 of this form. This health form must be completed and returned to Ewing Recreation Office before child participates in camp activities.

SECTION 1 TO BE COMPLETED BY THIS CHILD'S PARENT/GUARDIAN

Last Name: _____ First Name: _____ □ M □ F

Date of birth: _____ Age: _____ Home Phone: _____ Cell: _____

Address: _____
Street City State Zip

School Name: _____ Grade entering in fall. _____

Mother's Name: _____ Phone: _____ Cell: _____

Father's Name: _____ Phone: _____ Cell: _____

1. Emergency Contact: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell: _____

2. Emergency Contact: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Is your child taking prescription Medication? □Yes □ No
If yes please indicate which medication: _____

Will your child be taking medication during camp hours? □ Yes □No
If yes please indicate which medication: _____

*Please Note: your child's physician must fill out the Medication Consent Section on side two of this form in order for the camp to administer medication to your child.

Does your child have allergies: □ Yes □ No
If yes, what type:

Type of Allergy	*Life-Threatening*	*Type of Allergy*	*Life-Threatening*
☐ Bee stings: _____	☐	☐ Drugs: _____	☐
☐ Peanut: _____	☐	☐ Foods: _____	☐
☐ Tree nut: _____	☐	☐ Other: _____	☐
☐ Pollen, trees, grass, weeds, etc.		_____	

Please explain allergy in detail and what symptoms occur: _____
Does your child use an Epi Pen for the above allergy: □Yes □No
Does your child have any chronic or reoccurring illness? □Yes □No
If yes what type? Asthma □ Diabetes Type 1 □ Diabetes Type 2 □ Seizure Disorder □ Cardiac
□ Other _____

Please provide us with any additional information about your child's health, and update any medical conditions and/or changes that may have occurred within the past year that we should be aware of: _____

SIGNATURE OF PARENT/GUARDIAN _____ **DATE** _____
Use back of page for additional information

SECTION 2 TO BE COMPLETED AND SIGNED BY A LICENSED PYSCHCIAN THAT HAS EXAMIMED THE CHILD NAMED ON THIS FORM

Date of physical exam ____/____/____ Height _____ Weight _____ Date of last Tetanus shot ____/____/____

Is this child up to date on all required immunizations? □Yes □ No

Please provide us with information about this child's behavior, physical and/or emotional health, hospitalizations, operations, injuries, special restrictions and/or limitations that the camp should be aware of:_____

_____

Does this child have asthma? *Please Classify:* ☐Mild intermittent ☐Mild persistent ☐Moderate ☐Severe

Please explain the condition in detail:_____

_____

If this child has a cardiac condition, please explain in detail and list any restrictions or limitations:

_____

_____

Please provide medical information pertinent to routine care and emergencies:_____

_____

SECTION 3 MEDICATION CONSENT SECTION

This section is to be completed if this child will be taking medication while at camp (including any nonprescription drugs, or any over-the-counter medication, when prescribed by a physician)

Please note: In order to provide the highest quality care for all campers with food allergies, Ewing Recreation Summer Camp follows the guidelines set forth by the American Academy of Allergy, Asthma, and Immunology, who recommends that when a potentially life-threatening reaction to food occurs Injectable Epinephrine (Epi Pen) is used as a first line therapy. Oral antihistamines (Benadryl) will be only used as add-on therapy.

1. Medication: Dosage: Frequency:

Reason for medication:

Physician Signature:

2. Medication: Dosage: Frequency:

Reason for medication:

Physician Signature:

Physicians address print/stamp

This child is in good health and may engage in all camp activities:

Examining Physician's Name Print: _____

Signature: _____

Date:___/___/___ Physician Telephone: (_____) ____-_____

Please return to: Ewing Recreation Department 999 Lower Ferry Road, Ewing NJ 08628
609-883-1776 ext. 2