ARCHDIOCESE OF NEWARK CYO Day Camp
CAMP HEALTH HISTORY FORM – 2017 Camp

Participant _____ Age _____ Date of Birth _____ Sex _____

Mothers Name _____Home Phone_____Business Phone_____

Fathers Name _____Home Phone_____Business Phone_____

Home Address _____Town_____ Zip_____

Child resides with: Mom _____ Dad _____ Both Parents _____

Mom's Cell Phone # _____ Dad's Cell Phone # _____

This Child resides with _____ Both parents _____ Mom _____ Dad _____ Other

IF NOT AVAILABLE IN AN EMERGENCY PLEASE NOTIFY:

1._____
Name and Address Phone Relationship

2._____
Name and Address Phone Relationship

Has your child ever had or has … (please check off with approximate dates)

___Rheumatic Fever_____	___ Hay Fever_____	___ Chicken Pox_____
___Convulsions_____	___ Poison Ivy_____	___ Measles_____
___Diabetes _____	___ Insect Stings_____	___ German Measles____
___Allergies_____	___ Infections_____	___ Mumps_____

Operations or Serious Injuries (Dates)_____

Chronic or recurring Illness _____

What Medication is your child taking ?_____
(ALL MEDICATION MUST BE GIVEN TO CAMP EMT'S IMMEDIATELY UPON ARRIVAL)

PLEASE LIST ANY SPECIFIC ACTIVITIES TO BE ENCOURAGED/
DISCOURAGED_____

_____

BEHAVIOR HINTS FROM PARENTS_____

_____

_____

Physician's Name_____Phone #_____

Insurance Carrier_____ Policy number_____

Please list any specific allergies_____

Please list any Dietary restrictions _____

IMPORTANT: Please notify the Camp Director if the participant is exposed to any communicable disease during the three weeks prior to attendance.

PARENT'S AUTHORIZATION:
This Health History is correct so far as I know, and the person herein described has permission to engage in all prescribed activities except as noted by me.

Signature_____Date_____

MEDICAL RELEASE:
IN THE EVENT OF AN EMERGENCY WHERE MEDICAL TREATMENT IS REQUIRED I GIVE MY PERMISSION FOR THE DIRECTOR, STAFF, OR SPONSOR TO OBTAIN THE SERVICES OF A LICENSED PHYSICIAN. PLEASE ATTEMPT TO NOTIFY ME IMMEDIATELY CONCERNING ANY SUCH EMERGENCY.

SIGNATURE_____DATE_____

SURGICAL RELEASE:
IN THE EVENT OF AN EMERGENCY WHERE SURGICAL TREATMENT IS REQUIRED I GIVE MY PERMISSION FOR THE DIRECTOR, STAFF, OR SPONSOR TO AUTHORIZE THE NECESSARY SERVICES OF ANESTHESIA, SURGERY, AND MEDICATION PERFORMED BY THE PROPERLY LICENSED PHYSICIAN. PLEASE ATTEMPT TO NOTIFY ME IMMEDIATELY CONCERNING ANY SUCH EMERGENCY.

SIGNATURE_____DATE_____

This form MUST BE RETUNED BEFORE THE FIRST DAY YOUR CHILD ATTENDS CAMP.

DO NOT send us shot records. We would expect them to be on file at your doctor.

This should be mailed back with your child's registration.

This form DOES NOT need to be completed by a Doctor.