

Summer Camp "Theater Holidays"

Health Record and Release Form

Every camper must have this health record filled out for camp and brought to camp check-in. Camps held in the Maryland State require this form to be completed and signed by a **physician** before your child can participate at summer camp.

(Note: Please attach a copy of child medical insurance card)

PART A.

Child name: _____
Last First M.I.

DOB: _____ Age: _____ Sex: _____

SSN # _____

Parent/Guardian: _____

Address: _____

Phone (Home): _____

Phone (Cell): _____

Emergency Contact: _____

Phone: _____

Health History

Asthma: Yes/No

Loss of Limb: Yes/No

Diabetes: Yes/No

Orthopedic Problem: Yes/No

Heart Problem: Yes/No

Depression: Yes/No

Mono: Yes/No

Head Injury: Yes/No

Cancer: Yes/No

Migraine: Yes/No

Ear Infection: Yes/No

Tuberculosis: Yes/No

Please explain all "yes" answers _____

Other serious illness or injury: _____

List all current medications (Prescription, "over the counter" and herbal) _____

Health Insurance Provider: _____

Policy name/ID Number _____

Policy Holder's Name & DOB _____

Insurance Provider Contact Phone _____

Allergies

List all allergies (medication, food, etc) _____

Parent's Authorization

My child may participate in all activities at the Camp "Theater holidays". I give my child permission to be treated by emergency response personnel. I understand that every attempt will be made to contact me, or the emergency contact, before taking this action. I hereby waive and release the Camp staff, camp management and sponsors from any liability for any injury or illness incurred while at camp. I UNDERSTAND THAT THERE IS A RISK OF INJURY TO MY CHILD AS A RESULT OF CAMP ACTIVITIES, AND KNOWINGLY AND VOLUNTARILY ASSUME ALL RISK OF SUCH INJURY. I will be financially responsible for any medical attention needed during camp.

Parent Signature _____ Date _____

****Note**** All medication will be checked and kept by the camp health officer. Only prescription medication can be sent to the camp to be administered at the camp. All prescription medication must be in the original pharmacy container labeled with the child's name, the name of the drug, and instructions for administration. It is illegal for our health office to dispense medication from improperly labeled containers.

PART B.

Health examination by licensed physician

Examination is acceptable when performed no more than 12 month prior to arrival at camp.

Immunization History (Please List Dates)

Copy of Immunization Record preferable

DPT _____ Booster _____

Polio OPV (Sabin) _____ Booster _____

Measles/Mumps/Rubella (MMR) #1 _____ #2 _____

Meningitis _____ See form, Td _____

Tuberculin Test _____ Results _____

Hepatitis B #1 _____ #2 _____ #3 _____

Varicella _____

HIB #1 _____ #2 _____ #3 _____

Child has had the meningococcal meningitis immunization (Menomune™) within the past 10 years.

Date Received _____

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

Restrictions/limitations for camper while at camp? Yes/No

If yes, please explain: _____

Current treatment (include current medications): _____

Does applicant have epilepsy? Yes _____ No _____

Does applicant have diabetes? Yes _____ No _____

Any treatment to be continued at camp: _____

Any medication to be administered at camp (specific dosages): _____

Any medically prescribed meal plan or dietary restrictions: _____

Any allergies (food, drugs, plants & insects, etc.): _____

I have examined the person herein described, reviewed his/her health history and it is my opinion that he/she is physically able to engage in summer camp activities, except as noted above.

Physician's Name: _____

Address: _____

Phone: _____

Physician's Signature: _____

Date of Examination: _____