



Place current camper photo here

CAMPER HEALTH AND MEDICAL RECORD

UNIT _____ BUNK _____

CAMPER NAME _____	DOB _____
HOME ADDRESS _____	AGE _____ SEX _____
CITY / ZIP CODE _____	PHONE _____

DOCTOR'S NAME _____ PHONE _____ CHART # _____

EMERGENCY CALL INFORMATION (parent/spouse called first unless otherwise requested)

MOTHER/GUARDIAN _____ WORK PHONE _____
 _____ CELL PHONE _____

FATHER/GUARDIAN _____ WORK PHONE _____
 _____ CELL PHONE _____

Additional emergency names and phone numbers (three additional names required - neighbor, friends or relative)

- NAME /RELATION _____ HOME PHONE _____
 WORK PHONE _____ CELL PHONE _____
- NAME /RELATION _____ HOME PHONE _____
 WORK PHONE _____ CELL PHONE _____
- NAME /RELATION _____ HOME PHONE _____
 WORK PHONE _____ CELL PHONE _____

EMERGENCY MEDICAL INFORMATION (to be completed by parent/guardian)

ALLERGY: (medicine, food, insect toxin, other) _____

Medication used for allergies _____

Allergy medication sent to camp: YES _____ NO _____

HISTORY OF: Asthma _____ Convulsions _____ Diabetes _____ High fevers _____

Other medical conditions
 Explain _____

Any condition requiring medication _____

Medication for above _____

Medications brought to camp: YES _____ NO _____

Do you wear: glasses _____ contact lenses _____ braces _____ hearing aide _____

*If any medication is coming into camp, it must be accompanied by a note. The note should state the recipient's name, the medication name, amount to be given and time to be given. Prescription and "over the counter" medications **must** be in original, labeled bottles or containers. For prescription drugs, pharmacies will provide a duplicate empty bottle which is labeled and can be sent to camp with the medication. These rules apply to overnight and late stay medications as well as daily medications.

AUTHORIZATION

In the event my child requires emergency medical care (as determined by the "Y" administration) while he/she is under "Y" jurisdiction, I authorize the doctor(s) and hospital to which my child is brought to perform all necessary emergency procedures and render treatment including the administration of anesthesia as necessary. I understand that attempts will be made to contact parents/guardians (and the emergency numbers listed on this form as necessary) before initiating this authorization.

Date _____ Parent or Guardian _____



CAMPER NAME _____

ADDRESS _____

Physician's Name _____ Phone Number _____ Chart # (if applicable) _____

MEDICAL HISTORY (to be completed and signed by doctor)

IMMUNIZATIONS DATES

Measles _____	DPT _____
Mumps _____	Polio _____
Rubella _____	HiB _____
Chicken Pox _____	Hep B _____
TB: *Mantoux _____	Tetanus Booster: last received _____
Tine _____	

CURRENT OR PAST HISTORY:

	NO	YES	YEAR	DETAILS		NO	YES	YEAR	DETAILS
Injury	___	___	___	___	Deformity	___	___	___	___
Skin	___	___	___	___	Stomach	___	___	___	___
Glands	___	___	___	___	Bowels	___	___	___	___
Eyes	___	___	___	___	Hernia	___	___	___	___
Ears	___	___	___	___	Kidney	___	___	___	___
Nose	___	___	___	___	Bladder	___	___	___	___
Teeth	___	___	___	___	wetting	___	___	___	___
dentures _____				bridge _____	GYN	___	___	___	___
Chest	___	___	___	___	Heart :				
Bones	___	___	___	___	murmur	___	___	___	___
					other	___	___	___	___
Behavior	_____								
Neurologic	_____								
Contagious	_____								
Other	_____								

Date of last physical exam (form should be based on a physical performed within the past 12 months)

Physician's signature _____

***Please return this form to: Camp Veritans C/O "YM-YWHA", 1 Pike Drive, Wayne, New Jersey 07470**