

SAMPLE

CAMP \_\_\_\_\_ BUS \_\_\_\_\_ Number \_\_\_\_\_

LEWISBORO CAMP MEDICAL FORM

Camper's Name \_\_\_\_\_ Sex \_\_\_\_\_ D.O.B. \_\_\_\_\_ Home Phone # \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Mother's Name \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Please add one e-mail address \_\_\_\_\_

Father's Name \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Emergency Name (other than Parent) \_\_\_\_\_ Phone # \_\_\_\_\_

Doctor's Name \_\_\_\_\_ Phone # \_\_\_\_\_

Grade in Fall \_\_\_\_\_ School Area:  MP  IM  KT

Please list ONE child you would like your child to be placed with: \_\_\_\_\_

MEDICAL HISTORY/IMMUNIZATION RECORDS (exact dates, i.e. 4/28/07) - Required by N.Y.S. Health Dept.

Diphtheria/Pertusis/Toxoid (DPT) 4 doses DATES: 1) \_\_\_\_\_ 2) \_\_\_\_\_ 3) \_\_\_\_\_ 4) \_\_\_\_\_

Oral Polio Vaccine (OPV) 3+ doses DATES: 1) \_\_\_\_\_ 2) \_\_\_\_\_ 3) \_\_\_\_\_ 4) \_\_\_\_\_

Mumps/Measles/Rubella (MMR) 2 doses DATES: 1) \_\_\_\_\_ 2) \_\_\_\_\_

Hepatitis B (Hep B) 3 doses DATES: 1) \_\_\_\_\_ 2) \_\_\_\_\_ 3) \_\_\_\_\_

Haemophilus influenza type B (Hib) DATES: 1) \_\_\_\_\_ 2) \_\_\_\_\_ 3) \_\_\_\_\_

Varicella (Chicken Pox) DATES: 1) \_\_\_\_\_ 2) \_\_\_\_\_ or date of infection \_\_\_\_\_

Is your child taking any prescribed medication?  YES  NO Medication \_\_\_\_\_

Will your child need to take this medication during the camp day?  YES  NO

Is your child allergic to insect/bee bites:  YES  NO

Any Food Allergies \_\_\_\_\_ Drug Allergies \_\_\_\_\_

Other allergies/special needs/any other information that can help make your child's camp experience a positive one:

MEDICAL RELEASE: I hereby certify that my child is in normal physical and mental health. I give my child listed above permission to take part in all camp activities and trips unless otherwise indicated. I also understand that the Town of Lewisboro does not maintain medical insurance for program participants. Persons participating do so at their own risk. If I cannot be reached in the event of an injury, I give my permission for my child to be taken to a hospital for treatment to include evaluation of the injury, x-ray, and needed care.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Hospitalization/Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_

- Bus Transportation (please check one):  Increase Miller Elementary School  John Jay High School  Katonah Elementary School  Lewisboro Elementary School  Meadow Pond Elementary School  Oakridge Shopping Center  Town Park (Grades 4 & up only)  Vista Community House

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