110 Valley Road
Plymouth, MA 02360
(508)888-2634

SUMMER CAMP HEALTH FORM 2023

The original Signatures are required. Completed form must be received soon after registration or at the latest, one week prior to the camp session. Please download Health Form to the Camp's Website.

Camp Session Dates _____ to _____
Month/Day/Year Month/Day/Year

The following Health Information is to be filled out by Parent/Guardian/Doctor

CAMPER Name: _____ D.O.B: _____ Age at Camp: _____
Home address _____

Parent/Guardian with legal custody to be contacted in case of emergency

Name: _____ Preferred Phone #'s 1. _____ 2. _____
Email: _____

Second Parent/Guardian or other Emergency Contact

Name: _____ Relationship to Student: _____
Preferred Phone #'s: 1. _____ 2. _____ Email: _____

Additional Emergency Contact in the event parent/guardian cannot be reached

Name: _____ Relationship to Student: _____
Preferred Phone #'s: 1. _____ 2. _____ Email: _____

Permission to Provide Necessary Treatment or Emergency Care:

I hereby give permission to the medical personnel selected by the camp director to order x-rays, routine tests, treatment, to release any records necessary for insurance purposes, and to provide or arrange necessary related transportation for me/or my child. In the event I can not be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for the person named above.

Signature: _____ Date: _____

Insurance Information – Please fill out completely

Is the participant covered by family medical/hospital insurance? NO _____ YES _____

Insurance Company_____ Policy/Group number: _____

Participant ID number: _____Insurance Co. address: _____

Name of insured: _____ Relationship to insured: _____

Family Physician: _____ Phone: _____

Physician address: _____

Health History

The following information must be filled out by the parent/guardian. Please provide complete information so Camp can be aware of your needs.

Medications Taken

List all medications taken routinely (including over the counter drugs). Supply nurse with enough medications to last the entire camp stay. Keep medications in original bottle/package that identifies the prescribing physicians name, name of medication, dosage and frequency or administration.

Medications	Amount	Time Given
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

***Please identify and medications taken during the school year that participant does not take during the summer**

_____.

Permission for the Administration of Medication

I hereby give permission for the camp nurse to administer these, and those medication prescribed by the camp physician, for my child. I will be notified by Camp nurse of any prescription medicine prescribed by the camp physician. I also give permission to the camp nurse to provide basic care in case of sudden illness (I.E.: sore throat, fever, cold symptoms) and dispense over the counter medications as needed.

The following is a list of stocked non-prescription medications. Please check those your child could have on an **AS NEEDED BASIS** to manage illness and injury.

Acetaminophen (Tylenol) _____
Ibuprofen _____
Benadryl _____
Cough Drops _____
Sore Throat Drops _____

Calamine Lotion _____
Antibiotic Cream _____
Aloe _____
Tums _____

_____ _____

****Signature of Parent/Guardian** ****Date**

****PARENT GUARDIAN MUST SIGN ABOVE FOR CAMP NURSE TO BE ABLE TO ADMINISTER OVER THE COUNTER MEDICATIONS AS WELL AS PRESCRIPTIONS****

ALLERGIES

List all known allergies and describe reaction and treatment of reaction

Medication Allergies	Reaction and Treatment
_____	_____
_____	_____

Food Allergies	Reaction and Treatment
_____	_____
_____	_____

Other:

_____

_____.

DIETARY RESTRICTIONS

The participant DOES NOT eat the following:

_____Red Meat _____Poultry _____Pork _____ Seafood _____ Eggs _____ Dairy Products
Other foods: _____.

GENERAL HEALTH HISTORY – if yes, explain below.
Has or Does the Camper Have:

	YES,	NO		YES	NO
1. Had a recent injury illness or infectious disease	___	___	11. Have asthma? 12. Ever had seizures?	___	___
2. Ever been hospitalized?	___	___	13. Ever had chest pain?	___	___
3. Ever had surgery?	___	___	14. Have frequent ear infections?	___	___
4. Chronic or recurrent illness?	___	___	15. Had high blood pressure?	___	___
5. Ever had a head injury?	___	___	16. Have heart murmur?	___	___
6. Been knocked unconscious?	___	___	17. Any skin problems?	___	___
7. History of headaches?	___	___	18. Any back problems?	___	___
8. Have diabetes?	___	___	19. History w/bed wetting?	___	___
9. Wear glasses or contacts?	___	___	20. Have history fainting or dizziness?	___	___
10. Had/Have an eating disorder?			21. Been around anyone with covid In the last 14 days?	___	___

Please explain yes answers only in the spaces below indicated by number

_____
_____
_____
_____.

Has your child had Chicken Pox? NO _____ YES _____
Has your child had the Varicella Vaccine (Chicken Pox Vaccine)? NO _____ YES _____
Has your child had the Covid Vaccine? NO _____ YES _____ Dates of Vaccine (s): _____
Date of last Tetanus Vaccine: _____

****Please attach your child's most recent IMMUNIZATION and history/physical form SIGNED (can be electronically signed) by your child's physician** (This must be attached for students to be allowed onto campus). Medications should be included with a doctor's order on a signed history/physical form.**

Any restrictions to activities YES _____ NO _____ (If YES, please explain):

_____
_____.

Please note any additional information or suggestions regarding your child which may be helpful:

Emotional Stability: _____
Maturity: _____
Any personal problems: _____
Any behavioral problems: _____
Any learning problems: _____

HEALTH CARE RECOMMENDATION BY LICENSED MEDICAL PERSONNEL

I have examined the above camp participant. Date of last examination: _____

The above applicant _____**IS** _____ **IS NOT** able to participate in the active camp program.

The applicant is under the care of a physician for the following conditions:

_____
_____.

Current treatment at the time of report includes: _____
_____
_____.

RECOMMENDATIONS AND RESTRICTIONS AT CAMP BOURNEDALE

Treatment to be continued at camp: _____.

Medications to be administered at camp (name, dosage, frequency): _____
_____
_____
_____.

Any medically described meal plan or dietary restrictions: _____
_____
_____.

Known allergies: _____

Description of any limitations or restrictions on camp activities: _____

Additional information: _____
_____
_____
_____.

Signature of Licensed Medical Personnel: _____

Printed name of Licensed Medical Personnel: _____

Title: _____ Date: _____

Address: _____

Phone: _____