# Camp Bournedale

110 Valley Road
Plymouth, MA 02360
(508) 888-2634 | fax (508) 833-5187

## Health Form

Child's Name_______________________________ Date of Birth_____/_____/_____

Age______ Sex______ Name of School_________________________Grade________

Home phone#___________________________Cell phone#_______________________

Parent or Guardian________________________________________________________

Home Address____________________________________________________________

Place of Business__________________________Business phone_________________

Business Address__________________________________________________________

If not available in case of emergency, please contact:

| ____________________ | ____________________ | ____________________ |
|---|---|---|
| Name | Phone Number | Relationship |

Family Physician_______________________________Phone #___________________

Physician address_________________________________________________________

Please answer the following questions and explain any "yes" answers.

1. Will your child be under medical treatment for any condition(s) during this program?
No_______ Yes_______

2. Does your child have any chronic illnesses ? No_______ Yes_____

_____________________________________________________________________________

_____________________________________________________________________________

3. Should there be any restrictions on your child's activities? No_______ Yes_______

_____________________________________________________________________________

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

_____________________________________________________________________________

_____________________________________________________________________________

5. Has your child had Chicken Pox? No_______ Yes_______

6. Has your child had the Varicella Vaccine? No_______ Yes_______ (Date: _______)

7. When did your child receive his/her TETANUS shot? ______________

8. Does your child have any dietary restrictions?

______________________________________________________________________________

______________________________________________________________________________

9. Please list all of your child's ALLERGIES, including medicines, bee stings, environmental and food:

______________________________________________________________________________

______________________________________________________________________________

10. Please list any medications your child will need at camp. Prescribed medications must be in original container bearing a pharmacy label that shows the prescription number, date filled, physician's name, medication name and directions for use.

Non-prescription medications must be in their original containers with directions for use. All medication whether prescription or non-prescription must have physician's signature in order to be administered.

| Medication | Amount | Time Given |
| --- | --- | --- |
| | | |
| | | |
| | | |
| | | |

Physician's Signature___________________________________Date______________

I understand every effort will be made to contact me; however, IN CASE OF EMERGENCY, I hereby give permission to the physician selected by the camp's personnel to hospitalize, secure proper treatment for an order of injection, anesthesia, or surgery for my child. I give permission to the camp's nurses and staff members to supervise my child while taking the above medications and to administer first aid if needed. I also give permission to the camp nursing staff to provide basic care in case of sudden illness (I.E. sore throat, fever, cold symptoms) and dispense over the counter medications as needed.

Signature of Parent or Guardian          Date

Health Insurance Carrier          Policy Number

Name of Insured

**Should you have any questions please call our camp nurse at (508) 888-7197.**