BOYS & GIRLS CLUB OF CAPE COD SUMMER CAMP: MEDICAL HISTORY FORM

Child's Name ____Sex__________

Ethnic Background: African American____ / Asian _____ / Caucasian_____ / Hispanic_____ / Multi Racial_____
Native American ____ / Other___________________________________

Mailing Address____

City____State____________Zip___________________

Telehone____Date of Birth___________________________

Parent/Guardian #1

Name_______________________________ Relationship to Child:_______________Cell #_______________________

Parent/Guardian #2:

Name______________________________ Relationship to Child:_______________Cell #________________________

Address (If different from child's)____

Name of family physician_____________________________________Phone Number __________________________

Do you carry medical/hospital insurance? Yes___ No___

If so, please indicate: Carrier________________________________ Policy/Group # ____________________________

Please indicate those persons to whom your child may be released in case of injury/illness or dismissal: (Non-Guardian)

Name_______________________________________Phone_________________________Relationship_____________

Name_______________________________________Phone_________________________Relationship_____________

Is there a court order in regard to the Child's custody? Yes____________ No_______________

If yes, a copy of the restraining order is needed for the Club's file. Please attach to registration information.

Chronic or recurring illness/medical condition____

Dietary restrictions ____

Allergies ____

Current Medications ____

**Medications to be administered at camp____

* * An **Authorization to Administer Medication To A Camper** form must be completed prior to camp. Please contact the Camp Director with any questions. This form will be available prior to and on the first day of each session of camp. Medications MUST be brought to camp by a parent/guardian in a pharmacy labeled container.

Please indicate with a check (and dates if appropriate) if your child has experienced any of the following:
___ Frequent ear infections ___ Heart Condition/Disease ___ Seizures/Epilepsy ___ Diabetes ___ Asthma
___ Bleeding/Clotting Disorders ___ Hypertension ___ Mononucleosis ___ Lyme Disease.

Has your child had any of the following diseases (please give dates):
___ Chicken Pox ___ Measles ___ German Measles ___Mumps

In the event of illness or accident to my child while attending Camp, I hereby authorize the Director, or personnel selected by the Camp Director to administer and/or secure prompt medical treatment for my child. I also give permission to release any records necessary for insurance purposes and to provide or arrange related transportation for my child to the nearest medical facility as necessary. In the event I cannot 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 my child. This form may be photocopied for use out of Camp.
This health history is correct to the best of my knowledge, and the child herein described has permission to engage in all Camp activities except as noted.

Signature of Parent/Guardian ____ Date _______________________

You must provide the camp with an immunization history for your child and proof of a physical examination conducted by a physician within the last 24 months (24 months prior to the start date of camp). You may submit a copy of the physician's record or have your physician complete the following:

TO BE COMPLETED BY A PHYSICIAN

Immunization History (please give month and year of immunization)

MMR #1______________ MMR #2______________

Polio Vaccine: if IVP (3 doses required) # 1__________ #2__________ #3__________

if mixed IVP or eIVP (4 doses required) # 1__________ #2__________ #3__________ #4__________

DTaP/DTP/DT/Td (4 doses required) # 1__________ #2__________ #3__________ #4__________

(a Td boster is required every 10 years) date of last booster if applicable__________

Hepatitis B (for all children born after 1/1/92 - 3 doses required) # 1__________ #2_________ #3__________

Physical Examination by Licensed Physician
I have examined the above camp applicant within the past two years. Date examined _____________________________
In my opinion, the child listed above is able to participate in an active camp program with the following

Limitations: ____ No limitations _____________________________

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

____

Current treatment (include current medications): ____

____

Recommendations and restrictions while at camp (please indicate any treatments, medications, dietary restrictions):

____

Allergies (food, drug, plant, insect, etc.): ____

Licensed Physician's Signature____ Phone ________________________
Address ____

Date of Form Completion_____________________________________ By (initial if completed by nurse or PA)_________

PO BOX 895, MASHPEE, MA 02649 PHONE: 508-477-8845 FAX: 508-477-1991 info@boysgirlsclubcapecod.org