# Hi-Hills Day Camp

## Health History Form

**Campers will not be admitted to camp without this form.**

**(This form can not be used for Teen Travel)**

**Please mail or Fax this form ASAP to:**
**Hi-Hills Day Camp**
**PO Box 604**
**Gladstone, NJ 07934**
**Fax 908-234-0045**

Name ___________________________________Birth Date______/______/________ Age at camp_________ **(6/25/07)** Gender_____

Home Address ___________________________________________________________________________________________

**Street** **City** **State** **Zip**

Custodial parent/guardian ____________________________________________Phone__________________________________________

Home Address ___________________________________________________________________________________________

**Street** **City** **State** **Zip**

Business Address ________________________________________________________________________________________

**Street** **City** **State** **Zip**

Second parent or guardian or emergency contact __________________________________________Phone_________________________

Home Address ___________________________________________________________________________________________

**Street** **City** **State** **Zip**

Business Address ________________________________________________________________________________________

**Street** **City** **State** **Zip**

Physician's Name ________________________________________Physician's Phone Number____________________________________

Date of the most recent physical exam (month/year) ________/___________ (must have current physical w/in past 24 months)

Is the participant covered by family medical/hospital insurance? ☐Yes ☐ No

Is so, indicate carrier or plan name_________________________________________Group #_____________________________________

**Please indicate any allergies in the following categories.**

Medication_____________________________________________________________________________________

Food_________________________________________________________________________________________

Other_________________________________________________________________________________________

Please explain if the camper has any restrictions to activity while at camp___________________________________________________

_____________________________________________________________________________________________________

_____________________________________________________________________________________________________

_____________________________________________________________________________________________________

Please explain any dietary restrictions that your child may have____________________________________________________________

_____________________________________________________________________________________________________

_____________________________________________________________________________________________________

_____________________________________________________________________________________________________

**Please check all that apply. The camper has/does:**

- ☐ a recent injury, illness or infectious disease?
- ☐ a chronic or recurring disease?
- ☐ Frequent headaches?
- ☐ Had surgery?
- ☐ Nose or sinus problems?
- ☐ Frequent ear infections?
- ☐ Frequent eye infections?
- ☐ Glasses or corrective lenses?
- ☐ Passed out due to exercise?
- ☐ Been dizzy during exercise?
- ☐ Wear braces?
- ☐ Had seizures?
- ☐ Had a head injury?
- ☐ Problems with joints?
- ☐ Skin problems?
- ☐ Diabetes?
- ☐ Asthma?
- ☐ An eating disorder?
- ☐ Behavioral Conditions?
- ☐ Problems with diarrhea or constipation?
- ☐ Heart problems? (High BP, murmur?)

**Please explain any checked statements below.**_______________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

In the event of minor medical emergency or illness, the Camp Nurse has my permission to administer the following OTC medications.

☐Tylenol (Acetaminophen)  ☐ Benadryl  ☐ Cepacol Lozenges

**Please give all dates of immunizations for the following:**

| Vaccine: Dates: | Mo/Yr | Mo/Yr | Mo/Yr | Mo/Yr | Mo/Yr | Mo/Yr |
|---|---|---|---|---|---|---|
| DTP | | | | | | |
| TD(tetanus/diphtheria) | _____ | _____ | _____ | _____ | _____ | _____ |
| Tetanus | _____ | _____ | _____ | _____ | _____ | _____ |
| Polio | _____ | _____ | _____ | _____ | _____ | _____ |
| MMR | _____ | _____ | _____ | _____ | _____ | _____ |
| Or Measles | _____ | _____ | _____ | _____ | _____ | _____ |
| Or Mumps | _____ | _____ | _____ | _____ | _____ | _____ |
| Or Rubella | _____ | _____ | _____ | _____ | _____ | _____ |
| Haemophilus influenza B | _____ | _____ | _____ | _____ | _____ | _____ |
| Hepatitis B | _____ | _____ | _____ | _____ | _____ | _____ |
| Varicella (chicken pox) | _____ | _____ | _____ | _____ | _____ | _____ |

**Which of the following has the participant had?**

- ☐ Measles
- ☐ Chicken Pox
- ☐ German Measles
- ☐ Mumps
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C

Please list any other additional information that would be helpful to ensuring the best care for your child this summer. Please include any physical, emotional, or mental health information about which Hi-Hills Day Camp should be aware.__________________________

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

To the best of my knowledge this Health History is correct and complete. The camper has permission to participate in all camp activities unless otherwise noted on this form.

I hereby give permission to **Hi-Hills Day Camp** to provide, seek, and consent to routine medical health care, administration of prescribed medications, and emergency treatment for my child as may be necessary. This includes, but is not limited to: x-rays, routine tests and treatment, and/or hospitalization. I give permission to Hi-Hills to provide and transportation required for treatment. I understand that all medical bills for services to my child rendered by anyone other than the **Hi-Hills Day Camp** staff are my responsibility. I agree to release any records necessary for treatment, billing or insurance purposes.

It is my intention that the camp be treated as acting *in loco parentis* for my child. If I cannot be reached in the event of an emergency, I grant permission to **Hi-Hills Day Camp** to use the physician they have selected to secure treatment, including hospitalization.

Signature of Parent/Guardian ________________________________Printed Name________________________________ Date__________

Hi-Hills Camp at Gill St. Bernard's
PO Box 604
Gladstone, NJ 07934
Tel: 908-234-0067 Fax: 908-234-0045
Web: www.hihills.com
Email: hihills@gsbschool.org

## Medication Policy

When medication, prescription or over-the-counter, is to be administered to a camper during the camp day, the parents must bring the following to the Camp Nurse:

- Written orders from a physician giving the name of the drug, dosage, when medication is be taken, diagnosis and/or reason the medication is given.
- Written permission from the Parent or Guardian for the camp to comply with the physician's order.
- Medication in an appropriately labeled pharmacy container and/or an over-the-counter medication in its original container as purchased.

Note: The camp nurse may not administer medication which is not prescribed by a physician.

## Medication Permission Form

I hereby authorize the Hi-Hills Camp Nurse or her designated substitute to administer to:

______________________________________________
Camper's Name

____________________ __________ ____________________
Medication Dosage Time to administer

__________________________ ________________
Parent's signature Date

## Physician's Authorization

I prescribe (medication, dosage, and time) ______________________________
______________________________________________
______________________________________________
To be given to: (Camper's Name)______________________________

By the Camp Nurse or her designated substitute during camp hours for the reason(s) stated below:
______________________________________________
______________________________________________

Possible side effects or contradictions: ______________________________
______________________________________________

Curtailment of activity or special instructions: ______________________________
______________________________________________

Inhalers only: Is child authorized to carry and self-medicate? Yes ______ No _______

______________________________________________
Physician's Signature Telephone Number Date