

TORYMCA DAY CAMP

Health History & Physician's Form

Return To: Camp Torymca
259 Prospect Street
Torrington, CT 06790

This form must be received two weeks prior to camp.
Children are not permitted to attend camp unless form is complete. Everyone must submit an updated form each summer. This side to be completed by parent / guardian.

Name _____ DOB _____ Sex _____ Age _____

Last First Initial

Address _____ Phone _____

City _____ State _____ Zip Code _____

Mothers Name _____ Daytime phone _____ Employer _____

Fathers Name _____ Daytime phone _____ Employer _____

Camper lives with: _____ Both Parents _____ Mother _____ Father _____ Other _____

If other than Parent: Name _____ Phone _____

Address of Custodial Parent _____

MEDICAL INSURANCE _____

Carrier Name

For female camper-

Menstruation started: yes / no

Has understanding of: yes / no

Special Consideration: _____

Policy/Group # _____

Physician _____ Phone _____

Dentist _____ Phone _____

HEALTH HISTORY (Check / Dates) Hypertension _____ Allergies –please describe: _____

Frequent ear infections _____ Mononucleosis _____ Plants _____

Heart Defect/Disease _____ Chicken Pox _____ Insects _____

Convulsions _____ Measles _____ Medication _____

Diabetes _____ German measles _____ Food _____

Bleeding/clotting Disorders _____ Mumps _____ Other _____

Has this camper ever been stung by a bee? If yes, describe reaction and treatment, if any: _____

Does this camper have asthma? If yes, please describe treatment: _____

Has this camper ever received psychiatric counseling? _____

Operations or serious injuries (dates) _____

Disability or chronic/recurring illness: _____

Current medications: _____

Dietary restrictions: _____

Other details, instructions, or recommendations: _____

IMPORTANT—Below must be completed and signed for attendance

This health history is correct so far as I know, and the person herein describe has permission to engage in all prescribed camp activities except as noted.

Authorization for treatment: I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, treatment, and necessary transportation for me/or my child, and 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 me/or my child as named above. This form may be photocopied for use out of camp.

Signature (parent/guardian) _____ Date _____

*If for religious reasons you cannot sign this, then the camp should be contacted for a legal waiver

IMMUNIZATION HISTORY

Please record the date (month and year) of basic immunizations and most recent booster doses.

Vaccines	Year of Basic Immunization	Year of Last Booster
Diphtheria	1.	1.
Pertussis (Who. Cough) DPT*	2.	2.
Tetanus	3.	3.
or		
Tetnus		
Diphtheria TD*		
or		
Tetnus		
Oral Polio (Sabin)* TOPV		
Injectable Polio (Salk)		
Measles (Hard, red, Rubeola)		
Mumps		
Rubella (German, 3-day)		
Other		
Tuberculin Test	Given: (most recent)	
Haemophilus influenza b (HIB)		

HEALTH EXAM BY LICENSED PHYSICIAN:

I have examined the named camp applicant within the past 12 months. Date examined: _____

In my opinion, the applicant's condition does/does not preclude his/ her participation in an active camp program.

Height _____ Weight _____ Blood Pressure _____

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

Current treatment (include current medications): _____

Explanation of any reported lass of consciousness, convulsions, or concussion: _____

Does this applicant have epilepsy? YES___ NO___ Does applicant have diabetes? YES___ NO___

RECOMMENDATIONS AND RESTRICTIONS WHILE AT CAMP:

Any treatment to be continued at camp: _____

Any medication to be administered at camp (specific dosages): _____

Any medically prescribed meal plan or dietary restrictions: _____

Any allergies (food, drug, plants, insects, etc.) _____

Additional Health Information: _____

Licensed Physician's Signature _____ Phone _____

Address _____

Date form completed _____ * By _____

*Initial if completed by nurse or physician's assistant