

# TORYMCA DAY CAMP 2006

## Health History & Physician's Form

Return To: Camp Tormymca  
480 Main St.  
Winsted, CT 06098

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		
Tetanus		
Diphtheria TD*		
or		
Tetanus		
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 loss 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