



PLEASE RETURN BY APRIL 1st TO:
WINTER (September 1 - May 15)
 3 New King Street, White Plains, NY 10604
 p: 914-437-7200 f: 914-422-3635

SUMMER (May 16 - August 31)
 700 Churchill Street, Pittsfield, MA 01201
 p: 413-447-8900 / 800-494-6238
 f: 413-447-8905

CAMPER HEALTH HISTORY FORM 2012

TO BE COMPLETED BY PARENT / GUARDIAN

Camper Name (First, Middle, Last) _____ Birth Date _____

Camper Home Address: _____ City _____ State _____ Zip Code _____ Parent/guardian with legal custody to be contacted in case of illness or injury: Name: _____ Relationship to Camper: _____ Email _____ Home Phone: (____) _____ Cell: (____) _____ Summer Phone if different: (____) _____ Home Address (If different from above): _____ City _____ State _____ Zip Code _____ Second parent/guardian or other emergency contact: Name: _____ Relationship to Camper: _____ Email _____ Home Phone: (____) _____ Cell: (____) _____ Summer Phone if different: (____) _____ Additional contact in event parent(s)/guardian(s) can not be reached: Name(s): _____ Relationship to Camper: _____ Home Phone: (____) _____ Cell: (____) _____
Allergies: <input type="checkbox"/> No known allergies. <input type="checkbox"/> This camper is allergic to: <input type="checkbox"/> Food <input type="checkbox"/> Medicine <input type="checkbox"/> The environment (insect stings, hay fever, etc.) <input type="checkbox"/> Other <i>(Please describe below what the camper is allergic to and the reaction seen.)</i>
Diet, Nutrition: <input type="checkbox"/> This camper eats a regular diet. <input type="checkbox"/> This camper eats a regular vegetarian diet. <input type="checkbox"/> This camper has special food needs. <i>(Please describe below.)</i>
Restrictions: <input type="checkbox"/> I have reviewed the program and activities of the camp and feel the camper can participate without restrictions. <input type="checkbox"/> I have reviewed the program and activities of the camp and feel the camper can participate with the following restrictions or adaptations. <i>(Please describe below.)</i>
Medical Insurance Information: This camper is covered by family medical/hospital insurance <input type="checkbox"/> Yes <input type="checkbox"/> No Include a copy of your insurance card if appropriate; copy both sides of the card so information is readable. Insurance Company _____ Policy Number _____ Subscriber _____ Insurance Company Phone Number (____) _____
Parent/Guardian Authorization for Health Care: This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status. Signature of Custodial Parent/Guardian _____ Date: _____ Relationship _____ to Camper: _____ <i>If for religious or other reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance.</i>

