OUR KIDS DAY CAMP II, INC.

661 Budd Road
Woodbourne, NY 12788
Phone: 845-434-3788 Fx: 845-209-2587
helen@okdc2.com

CAMP HEALTH FORM

****The Camp Health Form MUST be filled out for each Camper EVERY year. PLEASE fill out both sides COMPLETELY and SIGN****

Camper Name_____ Birth Date_____ Sex_____ Age_____

Parents or Guardian_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Email Address:_____

Home Address_____
Street & Number City State/Zip

If not available in an emergency notify:

1)_____ Phone_____ 2)_____ Phone:_____
Name Name

Health History:

Circle Yes or No		Allergies		Has your camper had:	
Frequent Ear Infections	YES/NO	Hay Fever	YES/NO	Chicken Pox	YES/NO
Heart Defect/Disease	YES/NO	Poison Ivy	YES/NO	Measles	YES/NO
Convulsions	YES/NO	Insect Stings	YES/NO	Mumps	YES/NO
Diabetes	YES/NO	Penicillin	YES/NO	ASTHMA	YES/NO
Bleeding/Clotting Disorders	YES/NO	Other Drugs:	YES/NO if Yes, specify_____		

Operations or serious injuries YES/NO If yes, indicate what kind and dates_____

Chronic or recurring illness or disease?_____

_____

Special Diet? YES/NO If yes, specify _____

Are there any Activities your child should be restricted from at camp? YES/NO
If yes, Specify which ones: _____

- **MEDICATION**

ALL MEDICATIONS (OVER THE COUNTER OR PRESCRIBED) MUST BE KEPT IN THE OFFICE. ALL MEDICATION, INCLUDING OVER THE COUNTER, MUST BE PRESCRIBED BY A DOCTOR. PLEASE BRING ANY MEDICATION BEFORE CAMP STARTS. THE MEDICATION MUST BE IN THE ORIGINAL PRESCRIBED BOTTLE WITH THE TIME AND DOSAGE, INDICATED BY A DOCTOR.

Is your child taking any medications? YES/NO If yes, please indicate what kind_____

What is the medication for?_____

Are you sending medication to camp? YES or NO

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Does your child have any current physical, mental, or psychological conditions? If yes, indicate what kind

_____

Any Allergies? If yes, please indicate and if you are sending medication, what type._____

_____

_____

IMPORTANT: Please notify the camp if your camper is exposed to any communicable disease.

Name of dentist/orthodontist_____Phone_____

Name of family physician_____Phone_____

Do you carry family medical/hospital insurance? YES/NO
If yes, Indicate: Carrier:_____Policy or Group #_____

It is understood that the camper's medical insurance is the primary insurance, in case of medical attention.

IMMUNIZATION HISTORY Please attach a copy of your child's immunization record. All campers must have this on file.

Please initial
_____ If my child is sick, I will keep him/her home.

Accidents and injuries occur during sporting activities. Our Kids Day Camp cannot be held responsible for injuries occurring during these activities. We cannot be held responsible for medical expenses due to injuries or communicable diseases during camp.

Important –Permission to Treat

Parent's Authorization. This health history is correct. The camper described in this health form has permission to engage in all prescribed camp activities, except as noted.

I hereby give the camp medical personnel permission to treat my child within their medical credentials.

In case parents cannot be notified, in the case of an emergency, I hereby give permission to the physician selected by the camp director to order X-rays, routine tests and treatment for the health of my child. I also give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for my child as named above.

I HAVE READ THE CAMP'S POLICIES AND PROCEDURES WITH MY CAMPER AND WE FULLY UNDERSTAND ALL THE RULES AND REGULATIONS OF OKDC.

Parent Signature:_____ Date:_____