

MANDATORY HEALTH FORM: Complete BOTH sides

DO NOT MAIL THIS FORM. BRING IT TO CAMP ON OPENING DAY.

All participants must, according to state regulations, have this form completed and signed for camp attendance.

For participants under 18 years old: A parent or guardian must complete and sign this form at the bottom of this page.

Participants must have a physical conducted within 24 months of attendance, signed by a physician.

You may use the physician section of this form (back side), or attach your own copies.

Health form for all programs conducted at
Camp Wing/Duxbury Stockade – Camp Mitton – C5 New England/Camp Lapham
This form can be used by all participants, staff and campers



Name _____ Social Security Number _____ Birthdate ____/____/____ Age ____ M or F

Parent/Guardian Name _____ Home Phone _____ Work _____ Cell _____

Home Address _____

INSURANCE Name & Address: _____

Subscriber: _____ Policy #: _____ Group #: _____ Phone #: _____

EMERGENCY CONTACT: *Every effort will be made to contact the parent/guardian in the event of an illness or other problem. Please indicate 2 other persons who know your child, who have authorization for transportation, and who may be contacted if necessary.*

Name _____ Relationship _____ Telephone _____ Cell/Pager _____

Name _____ Relationship _____ Telephone _____ Cell/Pager _____

Name of family physician _____ Office Phone: _____ Location _____

Name of family dentist/orthodontist _____ Office Phone: _____ Location _____

GENERAL QUESTIONS (explain yes answers below):

- | Has/does the participant: | YES | NO | YES | NO | |
|----------------------------------------------------------|--------------------------|--------------------------|-----------------------------------------------------------------------------|--------------------------|--------------------------|
| 1. Had any recent injury, illness or infectious disease? | <input type="checkbox"/> | <input type="checkbox"/> | 8. Ever been hospitalized? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have a chronic or recurring illness/condition? | <input type="checkbox"/> | <input type="checkbox"/> | 9. Ever had seizures? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Wear glasses, contacts or protective eye wear? | <input type="checkbox"/> | <input type="checkbox"/> | 10. Have diabetes? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have any skin problems (e.g., itching, rash, acne)? | <input type="checkbox"/> | <input type="checkbox"/> | 11. Have asthma? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Had any problems with diarrhea/constipation? | <input type="checkbox"/> | <input type="checkbox"/> | 12. Have a history of bed-wetting? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. If female, have an abnormal menstrual history? | <input type="checkbox"/> | <input type="checkbox"/> | 13. Ever had emotional difficulties for which professional help was sought? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Ever had an eating disorder? | <input type="checkbox"/> | <input type="checkbox"/> | | | |

Please explain any "yes" answers, noting the number of the questions. Also, use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which the camp should be aware.

This health history (sides one and two) is correct as far as I know and the person herein described has permission to engage in all camp activities except as noted. **Authorization for release of information.** I hereby authorize Crossroads for Kids to obtain and/or release whatever educational, psychological, or medical information and records as deemed necessary. **Authorization for Distribution of Prescriptions:** I hereby authorize Crossroads for Kids to administer, to the person herein described, the medications (listed above or prescribed while at camp by a physician), in accordance to the regulations listed in CMR101. **Authorization for Routine Medical Treatment:** I hereby authorize the Camp to give routine medical care as outlined in the standing orders for the camp. **Emergency Authorization:** I hereby give permission to the medical personnel selected by the Camp Director to order x-rays, routine tests, and treatment 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 hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for me/or my child as named above. This form may be photocopied for use out of camp. I will assume all financial responsibilities for emergency treatment for me/or my child not covered by the camper medical insurance.

► **Signature of Parent/Guardian** _____ Date _____

Participants 18 or older may sign this form on their own behalf.

For official use only—Program (check): Camp Wing Day Camp Camp Wing Overnight
 Camp Mitton Camp Lapham Staff

OVER

LAST NAME

FIRST NAME

GENDER

DATE OF BIRTH (m/d/y)

AGE

