



**MUST BE COMPLETED & RECEIVED PRIOR TO CAMP**

The information on this form is to assist us in planning appropriate care. Updates should be provided to the office as they occur.

Staff's Name \_\_\_\_\_  
Last First Middle

Birth date \_\_\_\_\_ Age at camp \_\_\_\_\_ Present Grade (2021 - 2022) \_\_\_\_\_ Gender \_\_\_\_\_

Home address \_\_\_\_\_ Primary phone \_\_\_\_\_  
Street address City Zip

Father's Name \_\_\_\_\_ Home address \_\_\_\_\_  
(if different from above)

Business Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Mother's Name \_\_\_\_\_ Home address \_\_\_\_\_  
(if different from above)

Business Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Emergency Contact (Other than parents) Relationship Home/Work/Cell Phone

\_\_\_\_\_  
\_\_\_\_\_

**Allergies** (List all known) Describe reaction and management of the reaction.

Medication allergies (list)

\_\_\_\_\_  
\_\_\_\_\_

Food allergies (list)

\_\_\_\_\_  
\_\_\_\_\_

Other allergies (list) – include insect stings, hay fever, asthma, animal dander, etc.

\_\_\_\_\_  
\_\_\_\_\_

**Restrictions** (The following restrictions apply to this individual.)

Food: Red meat \_\_\_ Pork \_\_\_ Dairy Products \_\_\_ Poultry \_\_\_ Fish/Seafood \_\_\_ Eggs \_\_\_ Other (describe) \_\_\_\_\_

**Activity Restrictions:** (e.g. What accommodations or limitations are necessary?)

\_\_\_\_\_

*IN THE EVENT THAT I OR MY CONTACTS CANNOT BE REACHED IN AN EMERGENCY, I HEREBY GIVE MY PERMISSION TO PARK SHORE, THE LOCAL AMBULANCE/FIRE DEPARTMENT, MY FAMILY PHYSICIAN, ANY LOCAL PHYSICIAN, OR THE NEAREST HOSPITAL TO ADMINISTER EMERGENCY TREATMENT AND CARE. I FURTHER GIVE MY PERMISSION FOR ALL PERTINENT HEALTH INFORMATION TO BE DUPLICATED AND RELEASED TO THE APPROPRIATE PERSONNEL FOR EMERGENCY CARE.*

Signature/Parent/Legal Guardian Signature

Date

**TO BE COMPLETED BY PARENT/LEGAL GUARDIAN**

**MEDICATIONS**

Please list ALL medications (including over the counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the child's name, the prescribing physician (if a prescription drug,) the name of the medication, the dosage, route, and the frequency of administration. Ensure that medications are not expired. A **Medication Administration Form** (this form can be downloaded from our website) **MUST accompany all medications to be administered, routine or on an 'as needed' basis.**

This person <b>takes NO medications</b> on a routine basis. OR ___ This person <b>takes medications</b> as follows:	
Med #1 _____ Dosage _____	Specific times taken each day _____
Reason for taking _____	
Med #2 _____ Dosage _____	Specific times taken each day _____
Reason for taking _____	

**GENERAL QUESTIONS** (Explain "yes" answers below)

Has/does the participant?	Yes	No		Yes	No
1. Had any recent injury, illness, or infectious disease?			15. Ever been diagnosed with a heart murmur?		
2. Have a chronic or recurring illness/condition?			16. Ever had back problems?		
3. Ever been hospitalized?			17. Ever had problems with joints (e.g. knees, ankles)?		
4. Ever had surgery?			18. Have an orthodontic appliance being brought to camp?		
5. Have frequent headaches?			19. Have any skin problems (e.g. itching, rash, acne)?		
6. Ever had a head injury?			20. Have diabetes?		
7. Ever been knocked unconscious?			21. Have asthma?		
8. Wear glasses, contacts, or protective eyewear?			22. Had mononucleosis in the past 12 months?		
9. Ever had frequent ear infections?			23. Had problems with diarrhea/constipation?		
10. Ever passed out during or after exercise?			24. If female, have an abnormal menstrual history?		
11. Ever been dizzy during or after exercise?			25. Have a history of bed-wetting?		
12. Ever had seizures?			26. Ever had an eating disorder?		
13. Ever had chest pain during or after exercise?			27. Ever had emotional difficulties for which professional help was sought?		
14. Ever had high blood pressure?			28. Have Additional Health Concerns?		

Please explain any "yes" answers, noting the number of the questions: \_\_\_\_\_

Name of family dentist/orthodontist \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Are you COVID vaccinated? \_\_\_\_\_ YES \_\_\_\_\_ NO Which Brand \_\_\_\_\_

FIRST SHOT DATE: \_\_\_\_\_ SECOND SHOT DATE: \_\_\_\_\_

**SEE ATTACHED FOR ANNUAL MEDICAL FORMS** – TO BE COMPLETED BY PHYSICIAN

The Department of Health regulations require a complete ANNUAL physical exam in order to attend & participate in camp.

Please have your physician complete the attached form: annual physical exam & Immunizations/vaccinations.

**FOR HEALTH OFFICE USE ONLY**

STAFF PROFILE: \_\_\_\_\_

STAFF ANNUAL PHYSICAL EXAM: \_\_\_\_\_

STAFF IMMUNIZATION/VACINATION RECORD: \_\_\_\_\_

FANE REPORT: \_\_\_\_\_

ENTER COMPUTER: \_\_\_\_\_

STAFF Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_