HEALTH RECORD FOR CHILDREN ATTENDING CAMP GOOD GRIEF

(This side is to be filled out by the parent or guardian before giving the form to the medical professional)

Child's name: _____ Birthdate: __/__/__ Sex: Male Female
Home Address: _____ Phone: _____
Mother/Guardian: _____ Cell: _____
Father/Guardian: _____ Cell: _____
Emergency Contact: _____ Phone: _____
If parent or guardian is not available in an emergency notify:
1st _____ Phone: _____
2nd _____ Phone: _____

Has the camper been exposed to any **communicable diseases** during the 3 weeks prior to camp? Yes _____ No _____ (If so, what? _____)

HEALTH HISTORY (Check all that apply and give approximate dates)
Allergies_____
_____
_____

Asthma	_____	Hay Fever	_____	Rheumatic Fever	_____
Chicken Pox	_____	Insect Bites	_____	Penicillin	_____
Diabetes	_____	Poison Ivy	_____	Other Drugs	_____
Seizures	_____	Foods	_____	Please specify	

_____

Other Past Illnesses _____
Operations (give dates) _____
Serious Injuries (give dates) _____
Hospitalizations (give dates) _____
Chronic or Recurring Illness _____
Conditions that require restricted activity _____
Appliances worn (glasses, contacts, teeth) _____
Medications taken _____
_____
Other information _____
Signature _____ Relationship _____ Date __/__/__

PHYSICAL EXAMINATION

(Filled out by the physician/ physician's assistant – please note all appropriate additional information) The purpose of this health record is to provide the staff with pertinent information which will help to serve the needs of this child while in camp.

IMMUNIZATION HISTORY (This is a record of the dates of basic immunization and most recent booster doses)

DTAP, DTP, DT, TD	Date _____	Date _____	Date _____	Date _____	Date _____
Polio	Date _____	Date _____	Date _____	Date _____	Date_____
MMR	Date _____	Date _____	Date _____		
Hemophilus Influenzac type b (Hib)	Date _____	Date _____	Date _____	Date _____	
Hepatitis B	Date _____	Date _____	Date _____	Date _____	
Varocella	Date _____	Date _____			
Pneumonococal	Date _____				
Conjugate (PCV)	Date _____	Date _____	Date _____	Date _____	Date _____
Other	Date _____	Date _____	Date _____	Date _____	Date _____

MEDICAL EXAMINATION (To be filled out by a licensed physician/physician's assistant. Form is acceptable when performed no more than 12 months prior to arrival at camp)

Code: S= Satisfactory X= Unsatisfactory (Explain) O= Not Examined

General Appearance_____

Genitalia _____

Height _____ Weight _____ Blood Pressure _____ Posture & Spine _____ Throat _____

Nose _____ Teeth _____ Abdomen _____ Hernia _____ Feet _____

Lungs _____Skin _____ Eyes _____ Vision _____ Extremities _____ Heart _____

Ears _____ Hearing _____

Hemoglobin Test (Date) _____ Urinalysis (Date) _____

Neurological Findings _____

Describe Abnormal Findings and/or Handicapping Conditions _____

_____

_____

Allergy (Specify)_____

Recommendations and restrictions while at camp _____

_____

_____

Special Diet_____

_____

Medication (dose, route of administration and when it should be administered _____

_____

_____

General Appraisal:

I have examined the person herein described, reviewed his/her health history and it is my opinion that he/she is physically able to engage in camp activities, except as noted above.

_____ _____

Signature Physician / Physician's Assistant Print Name

Phone _____ Address _____

Zip Code _____ Date of Examination _____

EMERGENCY AUTHORIZATION TO TREAT A MINOR

I (we) the undersigned parents or legal guardians of: _____

_____

in case of emergency, give permission to the physician, nurse or other medical personnel selected by the Camp Good Grief of Staten Island staff to contact us, and treat or hospitalize my child(ren) if necessary. As the parent or legal guardian of the applicant, I give my permission for my child(ren) to participate in all camp functions. I certify that the health history and record which I have submitted to Camp Good Grief is correct to the best of my knowledge and my child(ren) have permission to engage in all camp activities unless otherwise noted on this form.

In addition, I have read and understand this Emergency Authorization and give my full consent to the terms found therein. I give my permission for photocopying of my child(ren)'s health record.

Signature of parent or legal guardian: _____

Date: _____ Emergency contact number: _____

ACKNOWLEDGMENT & CONSENT FOR AUDIOVISUAL & OTHER MEDIA

Camp Good Grief of Staten Island may be filming, taking photographs and/or making video recordings during the camp session.

In signing this document you are giving your consent and permission to Camp Good Greif for the use of your camper's likeness, name and voice in any manner that Camp Good Grief or its authorized agents sees fit.

In signing this document you agree to hold harmless the photographer, videographer, his or her representatives, employees or any persons or corporations acting under this permission or authority or any persons or corporations for whom he or she might be acting, including any firm, publishing and/or distributing the finished product, in whole or in part, from any liability as a result of any normal use that may occur or be produced in the taking, processing, or reproduction of the finished product, its publication or distribution.

Signature of parent or legal guardian: _____

Print child(ren)'s name(s): _____

Date: _____