Camper Medical Form

The information on this form is not part of the camper Acceptance process, but is gathered to assist us in identifying appropriate care. Health history (first two pages) must be filled out by parents/guardians. Page 3 to be completed by Physician.

Mail this form to the address below:

Preston Center of Compassion
2780 Schurz Avenue
Bronx, New York 10465

Name _____ D.O.B._____ Gender Male Female
Last First

Home Address: _____
Street Address City State Zip

Custodial Parent/Guardian: _____ Cell Phone: _____

Home Address:_____ Home Phone: _____
(if different from above) Street Address City State Zip

Second Parent/Guardian/Emergency Contact: _____ Cell Phone : _____
(Please cirlce one)

Address: _____ Home Phone: _____

If above not available in an emergency, notify:

Name: _____ Cell Phone: _____

Relationship: _____ Alt. Phone: _____

Insurance Information

Is the participant covered by family medical/hospital insurance? Yes No

If so, indicate carrier or plan name: _____ Group # _____ Phone: _____

Parent/Guardian Authorization

This health history is correct and complete as far as I know. The person herein described has permission to engage in all camp activities as noted. I give permission to the camp to arrange any related transportation for this camper.

My child has my permission to participate in all camp activities in the Preston Center of Compassion Summer Recreational Program. In case of emergency, I grant permission for my child to be given medical treatment as prescribed by PCC medical staff, physician or hospital.

In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above with the understanding that parents will be notified ASAP. A copy of this form may accompany the camper on trips.

I also understand that medications will not be administered by PCC personnel except for the epi-pen and asthma inhaler/pumps.

Signature of Custodial Parent/Guardian: _____

Printed Name of Custodial Parent/Guardian: _____ Date: _____

Child's Name: _____ D.O.B. _____

Health History - The following information must be filled in by the parent/guardian.

Allergies List all Known

Medication allergies (list) Describe reaction and management of the reaction

_____ _____

_____ _____

_____ _____

Food allergies (list)

_____ _____

_____ _____

_____ _____

Other allergies (list)

_____ _____

_____ _____

_____ _____

List Medication(s) <u>that are dispensed at home: (PCC will only administer epi-pens & asthma Inhaler/Pumps)</u>

Med #1 _____ Dosage:_____

Med #2 _____ Dosage:_____

Med #3 _____ Dosage:_____

Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary). Is there anything you feel we should know about your childs health:

_____

_____

_____

_____

This health history is correct and complete as far as I know.

Signature of Custodial Parent/Guardian : _____

Printed name of Custodial Parent/Guardian: _____ Date: _____

Child's Name: _____ D.O.B. _____

This page must be completed by a licensed health care provider.

(Please attach proof of medical exam & immunization history.)

Please note that no child may participate in the Summer Recreational Program without a completed physical.

Date of Medical examination: _____ (Exam must be within past 12 months of camp attendance.)

This child is able to participate in all camp program activities. YES NO

This child has the following restrictions on camp activities:

_____

_____

_____

This child is up to date on all Immunizations: YES NO

If YES, **Please attach a copy of Immunization Record**
If NO, please explain: _____

_____

_____

This child is on the following Medication(s) that will be dispensed at home:

Med #1 _____ Reason: _____

Dosage:_____ Means of Administering _____

Hours _____ Possible Side Effects and Adverse Reactions: _____

Med #2 _____ Reason: _____

Dosage:_____ Means of Administering _____

Hours _____ Possible Side Effects and Adverse Reactions: _____

Name of Health Care Provider (please print):

_____ Title: _____

Signature of Health Care Provider: _____ Date: _____

Address: _____ Phone _____

MD STAMP Required in box below