



73 East Valley Brook Road
Long Valley, New Jersey 07853
Phone: (908) 876-3429

Office Use Only

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CAMPER MEDICAL HISTORY FORM

(To Be Completed By Camper's Parent/Guardian and returned to Meadowbrook within 60 days of enrollment. No camper will be permitted to attend camp without this form. Please Print.)

G: _____

B: _____

Name _____

Date of Birth _____ Height _____

Address _____

Age as of July 1, 2010 _____ Weight _____

City, State, Zip _____

Gender M F

Father's Name _____

Mother's Name _____

Father's Home Phone _____

Mother's Home Phone _____

Father's Work Phone _____

Mother's Work Phone _____

Father's Cell Phone _____

Mother's Cell Phone _____

Family Status: Married Divorced Separated
(circle one) Single Widowed Other _____

Parent to contact 1st in Emergency _____

Emergency Medical Information (Circle)

Asthma

Convulsions

Fainting Spells

High Blood Pressure

Contact Lenses

Diabetes

Heart Trouble

Migraine Headaches

Allergy or reaction to any medicine, food, plants, and/or animal/insect toxin. Yes No (If yes, please explain)

Any other condition that may require emergency or special care, medicine or knowledge? Yes No (If yes, please explain)

Does your child require an Epi-Pen? Yes No

Has your child ever needed an Epi-Pen administered? Yes No

Does your child need to sit at a Nut-Free Lunch Table? Yes No

Insurance Information

Insurance Carrier/Plan Name: _____

Insurance Carrier Address: _____

Insurance Policy Number: _____

Group Number: _____

Prescription Plan #: _____

Medical Contact Information

Camper's Physician: _____

Phone: _____

Camper's Dentist: _____

Phone: _____

PLEASE COMPLETE THE REVERSE SIDE OF THIS FORM

Medical History

Any Past or Present History of: (please circle)

Back, Limbs, Joints	Yes	No	Heart	Yes	No	Serious Illness	Yes	No
Behavioral Condition	Yes	No	Heart Murmur	Yes	No	Serious Injury	Yes	No
Braces / Retainer	Yes	No	Hernia	Yes	No	Sinus	Yes	No
Chest, Lungs	Yes	No	Immune Deficiency	Yes	No	Skin, Glands	Yes	No
Contact Lenses	Yes	No	Kidneys	Yes	No	Stomach, Bowels	Yes	No
Deformity	Yes	No	Menstrual Problems	Yes	No	Surgery	Yes	No
Ears	Yes	No	Nose / Nosebleeds	Yes	No	Teeth	Yes	No
Eyes	Yes	No	Physical Limitations	Yes	No	Tonsils	Yes	No
Head Injury/Concussion	Yes	No	Pneumonia (recurrent)	Yes	No	Urine Infection	Yes	No
Hearing Aid	Yes	No	Rheumatic Fever	Yes	No	Other (explain below)	Yes	No

Please explain any Yes answers _____

Is camper currently under medical care? Y N (If Yes, Explain) _____

Does camper take any medication? Y N (If Yes, Explain) _____

Has camper been diagnosed with ADD or ADHD? Y N
 Does camper take medication for ADD or ADHD during the winter? Y N
 Will camper take the same medication for ADD or ADHD during the summer? Y N (If No, Explain) _____

AUTHORIZATION

To the best of my knowledge, the medical history is correct and complete. I know of no reason to restrict camper activity and give my permission for participation in all activities. I give permission for a Meadowbrook Country Day Camp staff member to administer an emergency Epi-Pen if deemed necessary. In the event I cannot be reached in an emergency, I hereby give permission to Meadowbrook Country Day Camp to take my child to the hospital or any outside physician selected by the camp when deemed necessary. Furthermore, I hereby give permission to such hospital or physician to hospitalize, secure proper treatment for, and/or order x-rays, routine tests, medications, injections, anesthesia and/or surgery for my child named above, without limitations. I understand that all medical bills for services rendered by anyone other than the camp's medical staff are my responsibility. I authorize the release of any medical information or records related to treatment, referral, billing or insurance purposes related to my child.

I further authorize the camp medical staff to discuss any medical conditions with the Director, his/her designee, or my child's counselor(s) when the medical staff, in its sole discretion, believes such communication to be in the best interest of my child.

Parent or Guardian Signature _____ Date _____