N.Y.S. Camp Directors Assoc.

brookhaven country day camp

Div. of Sunshine Camp Corp.

79 LONG ISLAND AVENUE YAPHANK, NEW YORK 11980

(631) 924-4033 Fax: (631) 924-4416 www.brookhavendaycamp.com E-mail: info@brookhavendaycamp.com

MEDICAL FORM

CHILD'S LAST NAME_____ **FIRST NAME**_____

BIRTHDATE _____/_____/_____ ☐ **MALE** ☐ **FEMALE**

ADDRESS_____ **HOME PHONE**_____

DIETARY RESTRICTIONS OR ALLERGIES_____

_____

OFFICE USE ONLY

GROUP

AUTHORIZATION FOR PEDIATRIC EMERGENCY MEDICAL AND/OR SURGICAL TREATMENT

Explanation: It is the firm hope that the authorization granted by this form would never need to be used. However, for the safety of the children, sound medical practice calls for such authorization. In emergency situations, where for some reason the parents of the child cannot be contacted immediately, this form will be extremely important. The authorization granted by this form will be used only where absolutely necessary and only after every attempt has been made first to contact the parent.

AUTHORIZATION: I authorize the camp to administer non prescriptive medications; Tylenol, Pepto Bismol, Benadryl, Calamine Lotion etc. as long as they are in their original packaging and my verbal permission is given.

AUTHORIZATION: In case of emergency, I hereby authorize the doctor or hospital to which my child may be brought (and whomever they may designate as their assistants) to perform any emergency procedure or operation, to give treatment and the administration of an anesthetic to my child during his/her stay in camp.

Health Insurance Company_____

Policy#_____ Parent Signature_____

I hereby give my permission for my son/daughter _____

to participate in all activities and field trips. Signed: _____ Date _____

Relationship to camper: _____ Address_____ Zip_____

CAMPER EMERGENCY INFORMATION

In case of emergency notify:

MOTHER'S NAME_____WORK PHONE_____CELL PHONE_____

FATHER'S NAME _____WORK PHONE_____CELL PHONE_____

EMERGENCY CONTACT_____ RELATIONSHIP _____ WORK PHONE_____ CELL PHONE_____

FAMILY PHYSICIAN_____ PHONE_____

IMMUNIZATION RECORD DATES

DPT or DTP_____ Polio_____

MMR_____ Hib_____

Hepatitis B_____ Varicella (Chicken Pox)_____

(PLEASE SEE REVERSE SIDE)

SIGNIFICANT HEALTH HISTORY
(to be completed by physician)

Allergies_____

Asthma_____ Diabetes_____

Motion Sickness_____ **Serious Accidents**_____

Fainting_____ **Tendency to excessive bleeding**_____

Past Illnesses (Check and give dates):

Seizures_____ Heart Abnormality_____

Chicken Pox_____**Operations**_____

Other_____

PHYSICAL EXAMINATION

Height_____ Weight_____ ☐ Glasses

General Appearance_____

Skin_____

HEENT_____

Heart_____**Lungs**_____**Abdomen**_____

Genitalia_____ Musculoskeletal_____

Neurologic_____

Describe abnormal findings and/or handicapping conditions:_____

_____

_____

Describe any dietary or medical regime:_____

_____

Any restrictions as to: SWIMMING_____

ATHLETIC ACTIVITES:_____

I believe this child is able to attend a summer program and participate in its activities.

Restrictions and/or recommendations:_____

_____

Name of Physician_____

Signed_____ **Date**_____ **Phone#**_____

Address_____