CAMP SOL SPAIN SUMMER CAMP

HEALTH RECORD/MEDICAL RELEASE FORM

This form must be completed and returned before camp enrollment dates in order for the camper to be permittted to participate in any camp activities. **Side A** - To be filled out by parent before presenting to camper's physician. **Side B** - To be filled out by camper's physician.

SIDE A: PERSONAL INFORMATION

Camper's Last Name _____ First Name _____ Birthdate _____ _ M _ F

Specify camp(s) child will be attending _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ e-mail _____

Guardian #1 _____ Guardian #2 _____

Daytime Phone _____ Daytime Phone _____

Health Insurance Carrier _____ Policy Number _____

Plan Number _____ Is physician authorization needed? _ YES _ NO

In case of emergency, please notify _____

If neither parent or guardian are available in an emergency, please contact:

1. _____ Daytime Phone _____

2. _____ Daytime Phone _____

HEALTH HISTORY (Please check approximate dates that camper suffered from allergies, diseases, and conditions listed below).

Diseases	**Allergies**	**Other**
❑ Chicken Pox_____	❑ Hay Fever _____	❑ Ear Infections_____
❑ Measles _____	❑ Poison Ivy _____	❑ Rheumatic Fever_____
❑ German Measles _____	❑ Insect Stings _____	❑ Convulsions _____
❑ Mumps _____	❑ Penicillin _____	❑ Diabetes_____
❑ Asthma _____	❑ Other Drugs _____	❑ Behavior_____
		❑ Concussion _____
		❑ Other _____

Please list any past illnesses (contagious and non-contagious): _____

Please list any operations or serious injuries (include dates): _____

Has camper ever been hospitalized? _____

Does camper have any chronic or recurring illness? _____

Is there anything else in campers health history that the camp staff should know? _____

Are there any activities from which the camper should be restricted?_____

Are there any specific activities that should be encouraged? _____

Will the camper be taking any medication at camp? _____

Does the camper wear any medical appliances (glasses, contact lenses, orthodonture, etc.)? _____

IF MEDICATION IS REQUIRED, IT MUST COME IN THE ORIGINAL CONTAINER WITH USAGE/DOSAGE/INSTRUCTIONS CLEARLY PRINTED ON LABEL. A DOCTOR'S NOTE AND PARENTS NOTE MUST ALSO BE SENT.

CONSENT FOR MEDICAL TREATMENT

I do hereby authorize that all of the above information is correct and that my child is fully able to participate in all Camp Sol Spain Camp activities without need of individual or specialized attention or medical regimen. I agree to notify Camp sol Spain of any changes in my child's physical or mental health between the dates of enrollment and the start of the camp as well as during camp. I hereby consent and authorize the administration of all medical treatments advisable or necessary under the judgement of the accredited camp trainers, emergency room physicians or any other clinical physicians with the understanding that I will be notified as soon as possible.

Name _____ Relationship _____

Signature _____ Date _____ Phone _____

SIDE B: To be filled out by camper's physician.

Name of Camper _____ Name of Physician _____

IMMUNIZATION HISTORY

Please provide us with a record of basic immunization and most recent booster doses for the camper listed above.

DTap, DTP, DT, TD	_____	Date	_____	Date	_____	Date	_____	Date	_____ Date _____
Polio	_____	Date	_____	Date	_____	Date	_____	Date	_____ Date _____
Measles	_____	Date	_____	Date	_____	Date	_____	Date	_____ Date _____
Rubella	_____	Date	_____	Date	_____	Date	_____	Date	_____ Date _____
Mumps	_____	Date	_____	Date	_____	Date	_____	Date	_____ Date _____
Hib	_____	Date	_____	Date	_____	Date	_____	Date	_____ Date _____
Hepatitis B	_____	Date	_____	Date	_____	Date	_____	Date	_____ Date _____
Varicella	_____	Date	_____	Date	_____	Date	_____	Date	_____ Date _____
PCV	_____	Date	_____	Date	_____	Date	_____	Date	_____ Date _____

Date of most recent Tetanus Shot _____

PPD-MANTOUX _____ Date Read _____

Most Recent Tuberclin Test Given _____ Result _____ ❑ m ❑ m

MEDICAL EXAMINATION Examination must be performed no more than 12 months prior to arrival at camp.

CODE: S = Satisfactory
X = Not Satisfactory (explanation required)
O = Not examined

General Appearance	_____	Height	_____	Weight	_____	Blood Pressure	_____
Hgb. Test	_____	Urinalysis	_____	Posture & Spine	_____	Throat - Tonsils	_____
Eyes	_____	Vision	_____	Glasses	_____		
Extremities	_____	Heart	_____	Ears	_____	Hearing	_____
Feet	_____	Lungs	_____	Skin	_____	Nose	_____
Teeth	_____	Abdomen	_____	Hernia	_____	Genitalia	_____

Neurological Findings: _____

Allergies (please specify): _____

Please describe any abnormal findings and/or handicapping conditions: _____

RECOMMENDATION AND RESTRICTIONS DURING CAMP

Special Diet _____

Special Medicine Needed _____ Is Parent Sending Medicine? ❑ YES ❑ NO

Strenuous Activity _____

General Appraisal _____

DOCTOR'S RELEASE

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 all Camp Sol Spain activities, except as noted above.

Examining Physician Signature _____

Physician Name (please print) _____

Address _____ Zip Code _____ Telephone _____

Date of Examination _____

PLEASE MAIL COMPLETED FORM TO:

Camp Sol Spain • 531 Main st • Ridgefield CT 06877