**MEDICAL OVERVIEW/CONSENT**
**(To be completed by parent)**

Camper's name: ______________________________________________
Last MI First

DOB: ______________________ Age: __________Gender: O Male O Female

Parent/Guardian name: ________________________________________________

Parent/Guardian phone numbers: (cell) ______________, (home) ___________________

Emergency contact (other than parent): _______________________________________

Emergency contact phone numbers: (cell) ____________, (home) ___________________

Physician's name: ____________________________________________________

Physician's Phone Number: ____________________________________

To ensure the safety of your child, other youth and the staff, please check off any of the following conditions that your child may have:

O Asthma O HIV/AIDS O A.D.D.

O A.D.H.D. O Behavioral problems O Allergic to bee stings

O Allergies O Emotional disorders O Heart ailments

O Food Allergies (list foods and reactions):_________________________________

O Other_____________________________________________________

Has your child visited a doctor within the last year for anything other than a physical or routine check-up?

O No O Yes if yes, please specify:_______________________________________

Please list any physical activities in which your child cannot participate:

______________________________________________________________

**HEALTH FORM**
**(To be completed by physician)**

Camper's name: ________________________________________________
Last MI First

**Health History:** (check and month/year)

O Asthma: _______________ O Behavioral Problems: ___________ O Concussion: ____________

O Ear infection: ___________ O Hay Fever: ___________________ O Chicken Pox: ____________

O Rheumatic Fever: _______ O Ivy Poisoning: _________________ O Measles: ________________

O Convulsions: _________ O German measles: ______________ O Mumps: _________________

O Diabetes: _____________

Operations or serious illness (dates):____________________________________________________

If answered yes to above, please provide details:
_____________________________________________________________________

_________________________________________________________________________________

**IMMUNIZATION HISTORY:** Required immunizations must be determined locally. This is a record of dates of basic immunizations and most recent booster doses. (Month/year) (A copy of the child's immunization record may be attached here)

DTP Series: ___________________ Booster:______________ Tetanus Booster: ___________________

Polio CPY (Sabin):_____________ Booster:______________ Typhoid:_____________________________

Measles Vaccine (live):___________ Tuberculin Test: ______________________

German measles (Rubella):_____________

Other:
_____________________________________________________________________________________

**Allergy History:**
(Yes/No)

Hay Fever: ______
Asthma: ______
Eczema: ______
Hives: ______
Insect Sting: ______
Food: ______

**Drug Reactions:**
(Yes/No)

Sulpha: ______
Penicillin: ______
Antibiotic: ______
Other: ______

(If yes, to what food/foods: _______________________________________________________)

If medication will be taken during camp, indicate name of the drug and dosage:

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Please list any pertinent medical information we should have regarding past injuries, past medical history, or suggested physical limitation relating directly to the participant's ability to participate in the camp for 7 hours a day.

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I certify that the above-named individual is able to participate fully in the activity listed above, based on physical examination within 12 months prior to said camp date.

______________________________ ______________________

(Signature of Physician) (Date)

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(Street Address) (City) (State) (Zip)

**Physician's Stamp Here:**

**This form is due to LifeCamp no later than June 1st. No child will be permitted to attend camp if this has not been received. Please mail to:**

**LifeCamp**
**310 South Street**
**4th Floor**
**Morristown, NJ 07960**