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)

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:

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.

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)

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

Physician's Stamp Here:

This form is due to LifeCamp no later than June 2nd. 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