



MEDICAL OVERVIEW/CONSENT
(To be completed by parent)

Camper's name: _____
Last MI First

DOB: _____ Age: _____ Gender: Male 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:

- Asthma
- HIV/AIDS
- A.D.D.
- A.D.H.D.
- Behavioral problems
- Allergic to bee stings
- Allergies
- Emotional disorders
- Heart ailments
- Food Allergies (list foods and reactions): _____
- Other _____

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

No 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)

- | | | |
|---|---|---|
| <input type="checkbox"/> Asthma: _____ | <input type="checkbox"/> Behavioral Problems: _____ | <input type="checkbox"/> Concussion: _____ |
| <input type="checkbox"/> Ear infection: _____ | <input type="checkbox"/> Hay Fever: _____ | <input type="checkbox"/> Chicken Pox: _____ |
| <input type="checkbox"/> Rheumatic Fever: _____ | <input type="checkbox"/> Ivy Poisoning: _____ | <input type="checkbox"/> Measles: _____ |
| <input type="checkbox"/> Convulsions: _____ | <input type="checkbox"/> German measles: _____ | <input type="checkbox"/> Mumps: _____ |
| <input type="checkbox"/> 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: _____)

Camper's name: _____
Last MI First

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 with the immunization information 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**