CARPATHIAN HOMES DAY CAMP
CAMPER MEDICAL & EMERGENCY CONTACT FORM

Also available online at www.carpathianhomes.com

Return the completed medical form by June 1, 2013 to:

CARPATHIAN HOMES DAY CAMP c/o Peggy Weiss
3205 Quentin Road
Brooklyn, New York 11234

Camper Name: ___________________________ Date of birth: ________________________

Mother's Name: __________________________ Father's Name: ___________________________

Address: ____

____

Summer address/bungalow number: ____

Home phone: __________________________ Cellular phone: __________________________

Work phone: __________________________ Cellular phone: __________________________

Emergency Contacts

1. Name: __________________________ Relationship: __________________________

   Phone number: __________________________

2. Name: __________________________ Relationship: __________________________

   Phone number: __________________________

Medicine/Food Allergies: ____

Daily Medication: ____

Restricted Activities for medical reasons: ____

Chronic or recurring illness: ____

Name of Dentist/Orthodontist: ___________________________________ Phone________________________

Name of Physician: ____ Phone________________________

Name of Insured: _______________________________________ Policy # _____________________________

Name of Insurance Company____

In case of medical emergency and in the event I can not be reached, I hereby give permission to the physician selected by Carpathian Homes to hospitalize, secure proper treatment for, and to order injections, anesthesia, or surgery for my child as named above. I understand that every effort will be made to contact me at the above phone numbers or my physician first. I also release Carpathian Homes and its staff from liability for injury or illness to my child resulting from his or her own negligence.

Parent/Guardian Signature: ______________________________________ Date: ________________________

(over)

PHYSICAL EXAMINATION FORM

To be completed and signed by Physician

Name of Camper: ____ Date of birth: ______________________

Height: ________ Weight: ________ Date of most recent complete physical exam: ________________

Medical History

ILLNESS	DATE	DETAILS
Chicken Pox		
Measles		
Diabetes		
Hernia		
Mumps		
Asthma		
Convulsions		
Appendicitis		
Whooping Cough		
Stomach Trouble		
Heart Trouble		
Ear Infections		
Rheumatic Fever		
Frequent Colds		
Kidney Problems		
Other (please explain)		

IMMUNIZATION RECORD: Please list last date given. ***You may choose to attach a printout instead.***

Diphtheria/DTP : _____________

MMR: _____________

Polio: _____________

Haemophilus Influenza Type B: _____________

TB Mantoux: _____________ (Result [positive or negative]): _____________

Last Tetanus Booster: _____________

Hepatitis B: _____________

Varicella (chicken pox): _____________

MEDICATION RECORD:

Will this child be bringing medication to camp? (Yes/No) _________

If so, please indicate type of medication, dosage, and schedule. All medication must be carefully marked with instructions, including a note of authorization from the parents that this medication may be administered by the Camp, with name of prescribing physician.

Type of medication and dosage times: ____

Physician Comments and Recommendations: ____

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I have examined the person herein described and have reviewed his/her health history. It is my opinion that he/she is physically able to engage in camp activities, except as noted above.

Physician Signature: ____ Date: ________________________

Address: ____

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Phone: ____ Facsimile: ___________________________________