P.O. Box 1286, Rocky Point, NY 11778 | P 631.744.0207 | F 631.744.3565 | www.nsyc.com

Camper/Counselor Health History Form

CAMPER/COUNSELOR INFORMATION:

Last Name:_____ First Name:_____ Home Phone:_____
Street Address:_____
City:_____ State:_____ Zip Code:_____
Date of Birth:_____ Age:_____ Grade Entering:_____ [ ] Male [ ] Female

PARENT/GUARDIAN INFORMATION:

Parent/Guardian #1:_____ Cell Number:_____
Parent/Guardian #2:_____ Cell Number:_____

EMERGENCY CONTACT: Local person to be contacted if either parent/guardian cannot be reached.

Name:_____ Relation:_____
Phone Number:_____ Address:_____

HEALTHCARE PROVIDER:

Physician's Name:_____ Phone Number:_____
Physician's Address:_____

ALLERGIES (please list all):

Food Allergies: [ ] Yes [ ] No If yes,_____
Medication Allergies: [ ] Yes [ ] No If yes,_____
Other Allergies: [ ] Yes [ ] No If yes,_____
Do you/does your child require an epi-pen? [ ] Yes [ ] No ***If yes, please enclose a copy of your physician's allergy plan.***
Are you/is your child allergic to trace content of any foods? [ ] Yes [ ] No If yes,_____
Are any of the above allergies severe or life threatening? [ ] Yes [ ] No If yes,_____
Describe allergic reaction and management of reaction:_____

_____

_____

MEDICATION:

Do you/does your child take any medication on a routine basis? [ ] Yes [ ] No
If yes, please list medications and reasons for taking:_____

_____

GENERAL HEALTH HISTORY: Has/does your child or you:

	Yes	No		Yes	No
Had any recent injury, illness, or infectious disease?	[ ]	[ ]	Ever been stung by a bee?	[ ]	[ ]
Have a chronic or recurring illness or condition?	[ ]	[ ]	Ever had Measles?	[ ]	[ ]
Ever been hospitalized?	[ ]	[ ]	Ever had Mumps?	[ ]	[ ]
Ever had surgery?	[ ]	[ ]	Ever had seizures?	[ ]	[ ]
Ever had a head injury?	[ ]	[ ]	Have diabetes?	[ ]	[ ]
Have frequent headaches?	[ ]	[ ]	Have asthma?	[ ]	[ ]
Have frequent ear infections?	[ ]	[ ]	Ever had Chicken Pox?	[ ]	[ ]

If yes, please explain. Please attach any copies of your physician's treatment/care plan(s):_____

_____

_____

_____

Describe any health conditions requiring special considerations or restrictions of any kind. Provide any additional information about the camper's/counselor's behavior and physical, emotional, or mental health of which the camp should be aware.

_____

_____

_____

IMMUNIZATION RECORD:

PLEASE PROVIDE AN UP-TO-DATE COPY OF YOUR/YOUR CHILD'S IMMUNIZATIONS FROM YOUR HEALTHCARE PROVIDER. THIS IS REQUIRED BY THE NEW YORK STATE DEPARTMENT OF HEALTH.

_____ ***is free of any communicable or contagious disease and has no physical, mental, or other conditions which would limit normal participation in camp activities except as noted above. If individual is under 18, parent/guardian must sign.***

Parent/Guardian Signature:_____ Date:_____

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Participant/Parent/Guardian Release

_____ has my permission to participate in all activities offered. If attempts to contact me are unsuccessful, I authorize and give my consent for any emergency medical, surgical or dental treatment for my child (listed above) anywhere/anytime should it be deemed advisable by a qualified medical Doctor or Dentist, and the prompt attention/treatment in an emergency. I authorize the North Shore Youth Council to take all necessary steps to ensure my child's health & safety in case of an emergency and to administer any needed medications.

In case of accident or injury I will not hold the North Shore Youth Council or its employees or volunteers responsible. I understand and assume all risks that may occur during my child's participation in these programs. I further acknowledge that North Shore Youth Council is not accountable for any injury/illness that may occur through no fault or negligence of their care, act of God, or communicable disease. I understand that should any injury occur to my child at the program, I will be responsible for all medical treatment and other costs through my medical insurance policy and/or personal finances.

Print Name of Parent/Guardian: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____