TOWN OF HUNTINGTON
DIX HILLS PARK
575 Vanderbilt Pkwy, Dix Hills, NY 11746 Att: Camp Program

CAMP MEDICAL/EMERGENCY FORM

MUST COMPLETE ALL 4 PAGES AND SUBMIT 1 MONTH PRIOR TO START OF SESSION

Please select camp(s) and session(s) your child is enrolled in:

Adventure Camp ☐ Skating Camp ☐ Hockey Camp ☐

PLEASE PRINT

Last Name_____First Name_____

Sex:_____ Home Phone: _____Date of Birth_____
(area code)

Address_____
Street Town Zip

Mother's Business #(__)_____Mother's Cellphone #:(__)_____

Father's Business #(___)_____Father's Cellphone #: (__)_____

****IF PARENTS CANNOT BE REACHED-EMERGENCY NUMBERS:**

1. Name:_____Phone #_____
(area code)
2. Name:_____Phone #_____
(area code)

PLEASE LIST THE INDIVIDUALS AUTHORIZED TO PICK UP YOUR CHILD:

Name_____Phone #_____

Name_____Phone #_____

HEALTH INSURANCE INFORMATION

CARRIER OR PLAN NAME_____Group #_____

NAME OF INSURED_____INSURANCE ID #_____

RELATIONSHIP TO PARTICIPANT_____

NOTE: All medication sent to camp MUST be labeled by pharmacy. We cannot administer medication.

ALL MEDICATIONS ARE SELF ADMINISTERED BY THE CHILD.

In the event that I cannot be reached by phone, I give my permission to the Camp Director or their appointed representatives to act in my behalf in seeking and providing medical treatment for my child during the camp season. This includes medical care and treatment by a first aid station or physician in a hospital.

Signature of Parent or Guardian_____Date_____

CAMP MEDICAL/EMERGENCY FORM (CONT'D)

TO BE COMPLETED BY A MEDICAL DOCTOR

IMMUNIZATION HISTORY (show dates of last immunization or booster)

NAME OF CHILD_____

IF CHILD BORN AFTER JANUARY 1, 1993 – MUST FILL IN DATES OF HEPATTIS B:_____

HAEMOPHILUS INFLUENZA T YPE B:_____ RUBELLA_____

MEASLES_____MUMPS_____HIB_____DPT_____

POLIO SALK/SABIN_____MMR_____ VARICELLA(chicken pox)_____

TBC: Date_____Results_____

_____is in good health, is not suffering from any illness and
Child's Name

_____MAY_____ MAY NOT____ participate in a full program of activities.

DIETARY/PHYSICAL RESTRICTIONS:_____

_____

I have prescribed the following medication for_____ which is self-administered

1. Name of medication:_____Dosage_____
2. Name of medication:_____Dosage_____

Purpose of medications:_____

ALL MEDICATIONS ARE SELF-ADMINISTERED BY CHILD

SIGNATURE OF PHYSICIAN:_____DATE:_____

PHYSICIAN'S NAME, ADDRESS, & PHONE NUMBER_____

_____

NOTE: All medication sent to camp MUST be labeled by pharmacy

CAMP MEDICAL/EMERGENCY FORM (CONT'D)

LAST NAME:_____FIRST NAME:_____

PLEASE TAKE THE NEXT FEW MINUTES TO ANSWER THE FOLLOWING QUESTIONS. REMEMBER: YOUR CHILD'S SAFETY AND HEALTH IS IMPORTANT TO US. PLEASE BE HONEST IN YOUR RESPONSES SO WE CAN DO EVERYTHING WITHIN OUR ABILITIES TO INSURE THAT YOUR CHILD HAS A GREAT TIME AT THIS SUMMER PROGRAM. IF YOU HAVE ANY QUESTIONS CONCERNING THE INFORMATION ON THIS FORM, PLEASE DO NOT HESITATE TO ASK US.

HAS YOUR CHILD *EVER HAD* OR *DO THEY NOW HAVE*: Please Check One

	YES	NO
(1) Asthma, wheezing, or inhaler use		
(2) Epilepsy, fits, seizures, or convulsions		
(3) Recurrent neck or back pain		
(4) Rheumatic fever		
(5) Dislocated joint, knee, hip, shoulder, elbow or ankle		
(6) Foot pain		
(7) Periods of unconsciousness		
(8) Frequent or severe headaches causing interruptions in school		
(9) Wear contact lenses		
(10) Fainting spells or passing out		
(11) Head injury, skull fracture, concussion		
(12) Seen a psychiatrist, psychologist, counselor or social worker		
(13) Skin disorders such as: Eczema Psoriasis Atopic Dermatitis		
(14) Irregular heartbeat, rapid or slow heartbeat		
(15) Thyroid condition or taking medication for thyroid		
(16) Limitation on movement or motion of joint, wrist, knee, hip, shoulder		
(17) Heart murmur, heart abnormality or problems		
(18) Heart surgery		
(19) High blood pressure		
(20) Hepatitis (liver inflammation or infection)		
(21) Any eye injury or surgery (other than corrective)		

NEXT PAGE…….

CAMP MEDICAL/EMERGENCY FORM (CONT'D)

Please Check

	YES	NO
(22) Allergies: common foods (milk, peanuts, eggs, meat, fish, etc.) wool or fabrics wasp, bee or any insect stings penicillin poison ivy drugs (prescription or medication) other: please specify_____		
(23) Broken bones requiring surgery to repair		
(24) Perforated ear drum or tubes in ear drums		
(25) Anemia (iron deficiency)		
(26) Pain or swelling at the site of an old fracture		
(27) Loss of appendage, limb or part thereof		
(28) Attention Deficit Disorder		
(29) Diseases: chicken pox german measles mumps tuberculosis measles other: please specify_____		
(30) If the answer to any of the above is "Yes" please reference the question number then Describe or explain with dates:		

MAIL ALL FORMS <u>ONE MONTH PRIOR TO SESSION TO</u>:

Dix Hills Ice Rink
575 Vanderbilt Pkwy Dix Hills, NY 11746
Att: Camp Program