

973 347-1230
973 691-4813 FAX

JEFFERSON LAKES DAY CAMP
PO Box 426
Stanhope, NJ 07874

PERSONAL HEALTH AND MEDICAL

Directions: To be completed by parent, guardian or physician - please complete both sides - the form is required by state law or child cannot attend camp.

Camper Name _____ Date of Birth _____
Address _____ Age _____ Sex _____
City _____ State _____ Home Phone _____
Business Phone: Father _____ Business Phone: Mother _____
Cell Phone: Father _____ Cell Phone: Mother _____
Camp Session Attending: 8 Weeks 1st Half 2nd Half Six Weeks (Specify Weeks) _____

IN AN EMERGENCY NOTIFY (someone close to camp who is available during the day)

Name _____ Name _____
Address _____ Address _____
City and State _____ City and State _____
Relationship _____ Relationship _____
Home Phone _____ Home Phone _____
Other Phone _____ Other Phone _____

EMERGENCY MEDICAL INFORMATION

- Asthma Fainting Spells Contact Lenses
- Convulsions Migraine Headaches Heart Trouble
- Diabetes High Blood Pressure Bee Sting
- Allergy or reaction to any medicine, food, plant, or insect toxin

APPROVED FOR PARTICIPATION IN (Please Check Box)

- All Activities
- Camp Trips
- Explain any restrictions or limitations below:

Any other condition that may require emergency or special care, medication or knowledge: Explain _____

IMMUNIZATIONS (must be completed each year as required by the State)

	<u>Month/Year Given</u>	<u>Check If Needed</u>	<u>Has Had:</u>	<u>Vaccination</u>	<u>Disease</u>	<u>Check if Needed</u>
Tetanus	_____	<input type="checkbox"/>	Measles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diphtheria	_____	<input type="checkbox"/>	Mumps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Polio	_____	<input type="checkbox"/>	Rubelia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MMR	_____	<input type="checkbox"/>	Whooping Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	_____	<input type="checkbox"/>	Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

MEDICAL HISTORY

Date of most recent physical exam (month and year) _____
Physician's Name _____ Phone _____
Address _____
Dentist/Orthodontist Name _____ Phone _____
Address _____

- Does your child currently take medicines? No Yes
- Is your child currently under medical care? No Yes
- Does your child currently have any health problems? No Yes (explain on back)
- Does your child currently have ADD or ADHD? No Yes
- Does your child take medication for ADD or ADHD during the winter? No Yes
- Does your child take this medication during the summer? No Yes

