



**Camp Netimus Medical Packet-Camper**

Parents: please complete pages 1 through 3 of this packet. A physician **must** complete the Camp Netimus Medical Form (page 4). If there are any medications or injections that must be given during camp, your physician must send specific written directions on the form and indicate any non-prescription medications the camper may need. **Only when all 4 pages are completed, signed and received in the camp office will the camper be able to participate in sports activities.**

Camper's Name: \_\_\_\_\_ Age at Camp: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Last First Middle month/day/year

Gender: \_\_\_ Female \_\_\_ Male If we admit your child to the Health Care Center after midnight in a non-emergency situation, do you prefer to be called regardless of the time? Please check: yes \_\_\_ no \_\_\_

Custodial Parent/Guardian \_\_\_\_\_ Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

City: \_\_\_\_\_ State/Country \_\_\_\_\_ Zip: \_\_\_\_\_ Work Phone: \_\_\_\_\_

E-mail: \_\_\_\_\_ FAX: \_\_\_\_\_

Second parent, guardian, or emergency contact: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

City: \_\_\_\_\_ State/Country \_\_\_\_\_ Zip: \_\_\_\_\_ Work Phone: \_\_\_\_\_

E-mail: \_\_\_\_\_ FAX: \_\_\_\_\_

Additional emergency contact: \_\_\_\_\_ Relationship to camper: \_\_\_\_\_

Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

City: \_\_\_\_\_ State/Country \_\_\_\_\_ Zip: \_\_\_\_\_ Work Phone: \_\_\_\_\_

E-mail: \_\_\_\_\_ FAX: \_\_\_\_\_

**Vacation Information while your child is at camp:** Please fill out this form or attach your travel itinerary.

Dates out of town: \_\_\_\_\_ Vacation location: \_\_\_\_\_ Contact phone number: \_\_\_\_\_

Dates out of town: \_\_\_\_\_ Vacation location: \_\_\_\_\_ Contact phone number: \_\_\_\_\_

Camper's Physician: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Camper's Dentist: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Camper's Orthodontist: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Other Doctor (specify): \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

I give Camp Netimus permission for my child to receive necessary care while at camp, including tests and medications; to get emergency medical treatment including emergency transportation and/or ordering routine tests or x-rays; to release any records required for necessary care and/or for insurance purposes.

In case I cannot be reached in an emergency, I hereby give permission to the physicians and hospitals selected by Camp Netimus to administer treatment, including hospitalization, for the camper named above.

This health form is complete and correct to the best of my knowledge. The camper named above has permission to participate in all camp activities except those noted.

**Signature of parent/guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Print your name please: \_\_\_\_\_

Camper's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Last First

Please answer the following questions:

- 1. A. Please list and describe any chronic or current illnesses of which the camp medical staff should be aware.
- B. How is this condition managed currently?

2. Are there any allergies?

Allergic to:	NO	YES	LIST known allergies and describe allergic reaction
Medications			
Food			
Bee Stings			
Other			

Are any specific medications required to address any of these allergic reactions? *\*See note at bottom of page.*

- 3. A. Please list and describe any dietary restrictions or issues.
- B. How is this condition managed currently?
- 4. A. Please list and describe any medical or behavioral conditions such as homesickness, sleepwalking, bed wetting, depression, ADHD, etc. of which the camp should be aware.
- B. How is this condition managed currently?

5. Has your daughter menstruated? Y / N If yes, date of first period\_\_\_\_\_Are her periods regular? Y / N  
 If no, has she been told about menstruation? Y / N

6. What medicines will the camper need to take while at camp?

Medication	Dosage	Frequency	Daily? As Needed?

\*All prescriptions/over the counter medications must be in their original container labeled with the camper's name, name of medication, strength of medication, and dosage. It is the parent's responsibility to provide sufficient medication for the child's entire length of stay. Campers **may not** keep medication in their cabins except for asthma inhalers. Please send 2 canisters. All medications must be turned over to the camp medical staff for administration.

**Camper's Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
Last First



7. If your child has any of the following health issues at home what is your usual remedy?
- A. Headaches
  - B. Nosebleeds
  - C. Cold symptoms/allergy symptoms
  - D. Menstrual cramps
  - E. Head lice; how was she treated and/or with what product(s)?

**Please contact the office if your child contracts head lice anytime after March 31.**

F. Other

**BE SURE TO INCLUDE A COPY OF BOTH SIDES OF YOUR HEALTH INSURANCE CARD.**  
**IN THE EVENT IT IS NECESSARY TO BRING YOUR CHILD TO THE HOSPITAL, THE HOSPITAL WILL REQUIRE A COPY OF HEALTH INSURANCE CARD.**

**Name of person insurance is enrolled under:** \_\_\_\_\_

**Social Security Number:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Address:** \_\_\_\_\_  
Street City State/Country Zip

**Name of Employer:** \_\_\_\_\_

**Address of Employer:** \_\_\_\_\_  
Street City State/Country Zip

**Insurance Company:** \_\_\_\_\_

**Address:** \_\_\_\_\_  
Street City State/Country Zip

**Phone Number:** \_\_\_\_\_

**Policy Number:** \_\_\_\_\_ **Group Number:** \_\_\_\_\_

**Camp Netimus Medical Form-Report by Licensed Health Care Provider**

**Camper's Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Date of Examination:** \_\_\_\_\_

**Camper's Height** \_\_\_\_\_ **Weight** \_\_\_\_\_ **Blood Pressure** \_\_\_\_\_

**Health History**

**Immunization History-Immunizations must be up to date**

<i>Vaccines</i>	<i>Date of Initial Series</i>	<i>Booster Date</i>
DPT/TD/Td		
HIB		
Measles/Mumps/Rubella		
Varicella (Chicken Pox)		
Polio		
Hepatitis A		
Hepatitis B		
<b>TETANUS-<u>must</u> have date</b>		
Meningitis		

<i>Condition</i>	<i>Check &amp; give approx. dates</i>
Frequent ear infections	
Heart defects or disease	
Seizures	
Diabetes	
Bleeding or clotting disorders	
Hypertension	
Chicken pox	
Other-Please list	
<i>Allergies</i>	<i>Specify as necessary</i>
Food	
Drugs	
Allergic Rhinitis	
Asthma	
Insect stings (systemic reaction)	
Other	

Indicate any current treatments and medications to be given at camp. Specify dosage and frequency.

Are there any play or physical restrictions? Please specify.

Are there any dietary restrictions?

Additional health recommendations-be specific:

Does camper wear an orthodontic appliance? \_\_\_\_yes \_\_\_\_no

Does camper wear glasses or contacts? \_\_\_\_no  
 \_\_\_\_glasses \_\_\_\_contacts

Does camper wear prosthesis or any other type of appliance?  
 \_\_\_\_no \_\_\_\_yes, please explain: \_\_\_\_\_

I have examined the above applicant on the date indicated. In my opinion, the above applicant's condition does not preclude her from participation in an active camp program.

**Licensed Provider's Signature** \_\_\_\_\_

**Print name of Provider** \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_