

TOWN OF BLOOMING GROVE SUMMER CAMP PROGRAM 2018
MEDICAL HISTORY FORM

Camper's Name _____ Phone (H) _____ (C) _____

Address _____
(Including name of road/street, P.O. Box #)

Age _____ Date of Birth _____

Are you a resident of the Town of Blooming Grove? Yes _____ No _____

(A resident pays property taxes to, and votes in Blooming Grove)

Emergency Name and Phone (not your own) 1. _____
Please List two Names 2. _____

MEDICAL HISTORY

Has your child been under any medical care within the past year? Yes _____ No _____

Reason: _____

Is the child on any medication now? Yes _____ No _____

What? _____

(Written Doctor approval is needed before the Camp Medical Personnel can administer medication)

Is your child allergic to Penicillin, or any other drug? Yes _____ No _____

What? _____

Does your child have other allergies? (i.e. bee stings, nuts, grass, etc.) Yes _____ No _____

What? _____

Is your child subject to:

- | | | |
|--|--|--|
| <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Wetting |
| <input type="checkbox"/> Stomach Upsets | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Abdominal Pains | <input type="checkbox"/> Cramps (Where? _____) | <input type="checkbox"/> Convulsions |
| <input type="checkbox"/> Frequent Sore Throats | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Serious Ivy/Oak/Sumac Poisoning | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Other _____ | | |

Does your child have: Lung Problems Kidney Problems Heart Problems

Hernia Epilepsy Other _____

Does your child have emotional, or mental limitations? Yes _____ No _____

If yes, please elaborate: _____

Has your child been exposed to any contagious disease in the past 3 weeks? Yes _____ No _____

If yes, what and when? _____

Should your child be restricted from any activity? Yes _____ No _____ If so, what? _____

IMMUNIZATION RECORD (Please indicate dates) Camper must have tetanus shot.

Optional~ Copy of medical records OR this section filled out and signed by a Physician

Tetanus - _____	Rubella - _____
Mumps - _____	Poliomyelitis - _____
Diphtheria - _____	Measles - _____
Chicken Pox - _____	Pneumonia - _____
Other - _____	Other - _____

Doctor's Name Printed _____ Office Address _____

Doctor's Signature _____ Office Phone # _____