TOWN OF BLOOMING GROVE SUMMER CAMP PROGRAM 2017

MEDICAL HISTORY FORM

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

Address_____

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

Age_____ Date of Birth_____ School_____ Grade_____

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:

___ Fainting Spells	___ Hay Fever	___ Headaches
___ Eczema	___ Tonsillitis	___ Wetting
___ Stomach Upsets	___ Diabetes	___ Asthma
___ Abdominal Pains	___ Cramps (Where?_____)	___ Convulsions
___ Frequent Sore Throats	___ Ear Infections	___ Sinus Trouble
___ Serious Ivy/Oak/Sumac Poisoning	___ Bronchitis	___ Constipation
___ 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 # _____