

**ARCHDIOCESE OF NEWARK CYO YOUTH MINISTRY
CAMP HEALTH HISTORY FORM – 2009 Camp**

Participant _____ Age _____ Date of Birth _____ Sex _____

Parent/Guardian _____ Phone (____) _____

Home Address _____ Town _____ Zip _____

IF NOT AVAILABLE IN AN EMERGENCY PLEASE NOTIFY:

1. _____
Name and Address Phone Relationship

2. _____
Name and Address Phone Relationship

HEALTH HISTORY: (CHECK, GIVING APPROXIMATE DATES)

<input type="checkbox"/> Rheumatic Fever _____	<input type="checkbox"/> Hay Fever _____	<input type="checkbox"/> Chicken Pox _____
<input type="checkbox"/> Convulsions _____	<input type="checkbox"/> Poison Ivy _____	<input type="checkbox"/> Measles _____
<input type="checkbox"/> Diabetes _____	<input type="checkbox"/> Insect Stings _____	<input type="checkbox"/> German Measles _____
<input type="checkbox"/> Allergies _____	<input type="checkbox"/> Infections _____	<input type="checkbox"/> Mumps _____

Operations or Serious Injuries (Dates) _____

Chronic or recurring Illness _____

What Medication is your child taking ? _____
(ALL MEDICATION MUST BE GIVEN TO CAMP DIRECTOR IMMEDIATELY UPON ARRIVAL)

PLEASE LIST ANY SPECIFIC ACTIVITIES TO BE
ENCOURAGED/DISCOURAGED _____

BEHAVIOR HINTS FROM PARENTS _____

Physician's Name _____ Phone # _____

Insurance Carrier _____ Policy number _____

Participants Name _____

Mothers Name _____ Home Phone _____ Business Phone _____

Fathers Name _____ Home Phone _____ Business Phone _____

PLEASE TURN OVER !

_____ Has legal custody of participant and may be released to him/her only or the

people named here _____

Please list any specific allergies _____

Please list any Dietary restrictions (A doctors note is required) _____

IMMUNIZATION HISTORY:

REQUIRED IMMUNIZATIONS MUST BE DETERMINED LOCALLY. THIS IS A RECORD OF DATES OF BASIC IMMUNIZATIONS AND MOST RECENT BOOSTER DATES.

DTP Series _____ Booster _____ Tetanus Booster ***** _____ Typhoid _____

Polio OPV _____ Booster _____ T.B. Test _____ Small Pox _____

Measles Vaccine _____ Booster _____ Mumps Vaccine _____ German Measles Live _____

(*)To be determined by Physician but at least within ten years.

IMPORTANT: Please notify the Camp Director if the participant is exposed to any communicable disease during the three weeks prior to attendance.

PARENT'S AUTHORIZATION:

This Health History is correct so far as I know, and the person herein described has permission to engage in all prescribed activities except as noted by me and the examining Physician.

Signature _____ Date _____

MEDICAL RELEASE:

IN THE EVENT OF AN EMERGENCY WHERE MEDICAL TREATMENT IS REQUIRED I GIVE MY PERMISSION FOR THE DIRECTOR, STAFF, OR SPONSOR TO OBTAIN THE SERVICES OF A LICENSED PHYSICIAN. PLEASE ATTEMPT TO NOTIFY ME IMMEDIATELY CONCERNING ANY SUCH EMERGENCY.

SIGNATURE _____ DATE _____

SURGICAL RELEASE:

IN THE EVENT OF AN EMERGENCY WHERE SURGICAL TREATMENT IS REQUIRED I GIVE MY PERMISSION FOR THE DIRECTOR, STAFF, OR SPONSOR TO AUTHORIZE THE NECESSARY SERVICES OF ANESTHESIA, SURGERY, AND MEDICATION PERFORMED BY THE PROPERLY LICENSED PHYSICIAN. PLEASE ATTEMPT TO NOTIFY ME IMMEDIATELY CONCERNING ANY SUCH EMERGENCY.

SIGNATURE _____ DATE _____

NO CHILD CAN ATTEND CAMP WITHOUT A COMPLETED HEALTH FORM ON FILE IN OUR OFFICE. PLEASE MAKE SURE WE HAVE THIS ON FILE BEFORE YOUR CAMPER STARTS