Camp Triumph Health Form

(**Filled out by Parent/Guardian** and returned with application)

Camper's Name ______________________ Birth Date ________ Age: (as of June 1) ________ Gender ______

Circle each week your child is attending camp: 1 2 3 (Period I) 4 5 6 (Period II) 7 8 (Period III)

Parent or Guardian ______________________ Phone ( ) ____________ Cell ( ) ____________

Home Address ______________________ Work Phone ( ) ____________
Street & Number City State Zip Code

Second Parent or Guardian ______________________ Phone ( ) ____________ Cell ( ) ____________

Home Address ______________________ Work Phone ( ) ____________
Street & Number City State Zip Code

Additional Emergency Contact ______________________ Phone ( ) ____________ Cell ( ) ____________
Name Relationship

Health History:
(check each item)

	Yes	No
Frequent ear aches	( )	( )
Convulsions	( )	( )
Diabetes	( )	( )
Bleeding/Clotting Disorders	( )	( )
Hypertension	( )	( )
Mononucleosis	( )	( )

Diseases:

	Yes	No
Chicken Pox	( )	( )
Measles	( )	( )
German Measles	( )	( )
Mumps	( )	( )

Allergies:

	Yes	No
Hay Fever	( )	( )
Poison Ivy (etc.)	( )	( )
Insect Stings	( )	( )
Penicillin	( )	( )
Asthma	( )	( )
Other Drugs	( )	( )
Food	( )	( )
Latex	( )	( )

Details of Allergic Reaction ______________________

Operations or serious injuries (dates) ______________________

Diagnosis, disability, chronic or recurring illness ______________________

Any specific activities to be limited by physician's advice ______________________

Dietary restrictions ______________________

Current medication (Send in original prescription bottle with instructions and sign back of this form) ____________

Other diseases or details of above ______________________

Name of dentist/orthodontist ______________________ Phone ( ) ____________

Name of Physician ______________________ Phone ( ) ____________

Date of last physical examination ______________________

Do you carry medical/hospital insurance? ____________

If so, please indicate: Carrier ______________________ Policy/Group Number ____________

Suggestions or health-related information for camp personnel ______________________

Please return all forms and correspondence to our
Main office at 36 Woburn Street. Reading, MA 01867.

Continued on Reverse Side

All parents/guardians should complete this top half

Do you give Camp Triumph permission to administer the following:

Yes	No	
___	___	Sunscreen (PABA free)
___	___	Insect Repellant (Spray or Lotion)
___	___	Tylenol (for headache or fever greater than 101.5 degrees F.)
___	___	Benadryl (if stung or for unusual bee sting reaction)
___	___	Benadryl (if hives develop) Administration of this medication will be followed by phone notification by Health Supervisor to parent.

Insect Sting & Allergy Information:

Type of insect: ______________________________ Last stung: ______________

Reaction to sting (in detail): ______________________________

____

Treatment: ______________________________

For insect stings and other applicable allergies an EPI-PEN must be provided by parents/guardian.

Asthma:

Last episode: ______________________________ How often? ______________

Triggers: ______________________ Symptoms: ______________________

I hereby certify that the above named camper is in good health and fully able to participate in all activities except those stated above. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the Director of Camp Triumph to hospitalize and/or secure treatment for my child.

Date ______________ Signature ______________________ If for religious reasons you cannot sign this, the camp should be contacted for a legal waiver which must be signed prior to enrollment.

To be completed by parents/guardians who are bringing medication to camp for their child

I hereby give permission to the Health Staff of Camp Triumph to administer the following medications to my child:
* Medicaltions must be in original prescription bottle.

*Please note that medications are administered only at the following times:
10:30 a.m., 12:00 p.m. and 1:30 p.m.

First Medication:

Name of medication:______________________________

When to be given: ____ 10:30 a.m. ____ 12:00 p.m. ____ 1:30 p.m.
(Check all that apply)

As prescribed by Doctor ______________________ Phone ______________

Any further instructions of medications will be sent in writing to the Health Staff of Camp Triumph.

Signature of Parent:______________________

Second Medication:

Name of medication:______________________________

When to be given: ____ 10:30 a.m. ____ 12:00 p.m. ____ 1:30 p.m.
(Check all that apply)

As prescribed by Doctor ______________________ Phone ______________

Any further instructions of medications will be sent in writing to the Health Staff of Camp Triumph.

Signature of Parent:______________________