DOROTHY P. FLINT NASSAU COUNTY 4-H CAMP **Session (s)** ______________

HEALTH INFORMATION— TO BE COMPLETED BY PARENT/GUARDIAN

NEW YORK STATE requires camps to have a completed health form for each child.

CAMPER'S NAME ____ ____________ _______ _______
Last *First* *Middle* *Birth Date* *Age* *Gender*

Parent or Guardian ____

Home address ____
Number and Street *City/State* *Zip+4*

Phone ( ) ____________________ ( ) ____________________ ( ) ____________________
Day *Evening* *Cell*

Other Parent or Guardian ____

Phone ( ) ____________________ ( ) ____________________ ( ) ____________________
Day *Evening* *Cell*

IF PARENT OR GUARDIAN CANNOT BE REACHED, NOTIFY ______________________________
Must be over 18 years of age

Relationship to Camper ____

Phone ( ) ____________________ ( ) ____________________ ( ) ____________________
Day *Evening* *Cell*

CAMPER'S NAME ____________ *Last Name* ____________ *First Name*

1 2 2S 3 3S 4 5 5S 6 6S 7 7S 8

MEDICAL INSURANCE Fill out completely OR attach a copy of your medical insurance card (front and back).

Policy Holder's Name	Name of Insurance carrier and type of coverage	Policy Number	Group Number

Authorization for release of information to above named insurance carrier

Signature ______________________ Date ______________

Relationship to camper (parent, etc.) ______________________

Address of Insurance Company ____

Your personal medical policy is your child's primary coverage. All campers must have medical insurance to attend camp.
All registered campers are covered by excess coverage accident insurance while at camp.

IMPORTANT **Please notify the camp office if this camper is exposed to any communicable disease during the three weeks prior to camp attendance.**

PERMISSION TO PROVIDE NECESSARY TREATMENT OR EMERGENCY CARE

I certify that the information given in this form and on the attached immunization record is current and correct. I hereby give permission to the medical personnel selected by the Camp Coordinator to order x-rays, routine tests, treatment, release any records necessary for insurance purposes, and to provide or arrange for necessary transportation for my child. In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the Camp Coordinator to secure and administer treatment, including hospitalization, for the person named above. This form may be photocopied for trips out of camp.

SIGNATURE OF PARENT OR GUARDIAN: ____

HEALTH INFORMATION— TO BE COMPLETED BY PARENT/GUARDIAN

FILL IN ALL REQUESTED INFORMATION. INCOMPLETE FORMS CANNOT BE PROCESSED AND WILL BE RETURNED.

CAMPER'S NAME ______________________________ **First time overnight camper?** ☐ Yes ☐ No

(Check YES or NO)

☐ Yes ☐ No asthma
☐ Yes ☐ No frequent ear infections
☐ Yes ☐ No heart defect/disease
☐ Yes ☐ No convulsions
☐ Yes ☐ No diabetes
☐ Yes ☐ No bleeding/clotting disorders
☐ Yes ☐ No hypertension
☐ Yes ☐ No psychiatric treatment
☐ Yes ☐ No mononucleosis
☐ Yes ☐ No bedwetting
☐ Yes ☐ No fainting
☐ Yes ☐ No eating disorder
☐ Yes ☐ No sleepwalking
☐ Yes ☐ No headaches

Operations or serious injuries (dates): ______________________________

Disability or chronic medical conditions: ______________________________

Current medication (send in original container with instructions): ______________

Dietary modifications: ______________________________

Any specific activities to be limited: ______________________________

Name of family physician: ______________________________

Phone: (   ) ______________________________

Allergies

☐ Yes ☐ No medications ______________
☐ Yes ☐ No foods ______________
☐ Yes ☐ No insect stings ______________
☐ Yes ☐ No poison ivy
☐ Yes ☐ No hay fever

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Diseases

☐ Yes ☐ No chicken pox
☐ Yes ☐ No measles
☐ Yes ☐ No German measles
☐ Yes ☐ No mumps

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MENINGOCOCCAL MENINGITIS VACCINATION

New York State Public Health Law requires the operator of an overnight children's camp to maintain a completed response form for every camper who attends camp.

REQUIRED—PLEASE CHECK ONE BOX AND SIGN BELOW

☐ My child has had the meningococcal meningitis immunization (Menomune™) within the past 10 years.

Date received: ______________ (Note: The vaccine's protection lasts for approximately 3 to 5 years. Revaccination may be considered within 3 to 5 years.)

☐ I have read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that my child will not obtain immunization against meningococcal meningitis disease.

☐ Please refer to immunization record

SIGNATURE OF PARENT/GUARDIAN ______________________________

REQUIRED SIGNATURES

I have read and discussed the 2016 Parent-Camper Handbook with my child. We agree to abide by all policies and procedures contained therein.

SIGNATURE OF PARENT/GUARDIAN ______________________________

SIGNATURE OF CAMPER ______________________________