Camp Bournedale

110 Valley Road
Plymouth, MA 02360
(508) 888-2634 | fax (508) 833-5187

Health Form

Child's Name_____ Date of Birth_____/_____/_____

Age_____ Sex_____ Name of School_____Grade_____

Home phone#_____Cell phone#_____

Parent or Guardian_____

Home Address_____

Place of Business_____Business phone_____

Business Address_____

If not available in case of emergency, please contact:

_____ _____ _____
Name Phone Number Relationship

Family Physician_____Phone #_____

Physician address_____

Please answer the following questions and explain any “yes” answers.

1. Will your child be under medical treatment for any condition(s) during this program?
No_____ Yes_____

2. Does your child have any chronic illnesses ? No_____ Yes_____

_____

_____

3. Should there be any restrictions on your child's activities? No_____ Yes_____

_____

4. Please note any additional information or suggestions regarding your child which may be helpful:

_____

_____

5. Has your child had Chicken Pox? No_____ Yes_____

6. Has your child had the Varicella Vaccine? No_____ Yes_____ (Date: _____)

7. When did your child receive his/her TETANUS shot? _____

8. Does your child have any dietary restrictions?

_____

_____

9. Please list all of your child's ALLERGIES, including medicines, bee stings, environmental and food:

_____

_____

10. Please list any medications your child will need at camp. Prescribed medications must be in original container bearing a pharmacy label that shows the prescription number, date filled, physician's name, medication name and directions for use.

Non-prescription medications must be in their original containers with directions for use. All medication whether prescription or non-prescription must have physician's signature in order to be administered.

Medication	Amount	Time Given
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Physician's Signature_____Date_____

I understand every effort will be made to contact me; however, IN CASE OF EMERGENCY, I hereby give permission to the physician selected by the camp's personnel to hospitalize, secure proper treatment for an order of injection, anesthesia, or surgery for my child. I give permission to the camp's nurses and staff members to supervise my child while taking the above medications and to administer first aid if needed. I also give permission to the camp nursing staff to provide basic care in case of sudden illness (I.E. sore throat, fever, cold symptoms) and dispense over the counter medications as needed.

_____ _____

Signature of Parent or Guardian Date

_____ _____

Health Insurance Carrier Policy Number

_____

Name of Insured

Should you have any questions please call our camp nurse at (508) 888-7197.