

VILLAGE OF HAMILTON

Due back by: June 23, 2023

(Send the original – and also bring a copy to camp)

PLEASE COMPLETE ENTIRE FORM!

Start Date: _____

End Date: _____

Student Name (print) _____

Age at camp ___ Birth Date: ___/___/___ Gender: M F

Address: _____

City _____ State: _____ Zip: _____

Phone Number (Day): (_____) _____

(Eve): (_____) _____

In Case of Emergency and parent / guardian cannot be reached:

Contact: _____ Relationship: _____

Phone: (_____) _____

Parent/Guardian Authorizations: This health history is correct and complete. The person herein described has permission to engage in all camp activities except as noted. I hereby give permission to the staff and volunteers of the Village of Hamilton Summer Recreation Program to provide routine healthcare and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to the Camp to arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I hereby give permission to the Director of YOUR CAMP or their designee to secure and administer treatment, including hospitalization, for the student named above.

Signature of Parent/Guardian _____

Printed Name _____ *Date* _____

Medical Insurance Company (REQUIRED)

Ins. Co. _____

Policy # _____ Group # _____

Insured Employer _____

We recommend that a photocopy (front and back) of health insurance card be attached to this form.

Health History:

<i>Check those that apply:</i>	<i>Life Threatening Conditions</i>
<input type="checkbox"/> Contact Lenses	<input type="checkbox"/> Ear Aches / Infection
<input type="checkbox"/> Gyn Problems	<input type="checkbox"/> Poison Ivy, Oak, Sumac
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Stomach Problems
<input type="checkbox"/> Sore Throat	<input type="checkbox"/> Absence of a paired organ
<input type="checkbox"/> Whooping Cough	<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Current orthodontic appliance	<input type="checkbox"/> Mononucleosis in the past 12 months
<input type="checkbox"/> Skin Problems (Acne, Eczema)	<input type="checkbox"/> Recent Illness / Infections
<input type="checkbox"/> HBP	<input type="checkbox"/> COVID-19
<input type="checkbox"/> Bone / Joint Injuries	<input type="checkbox"/> Concussion / Head Injury
<input type="checkbox"/> Operations	<input type="checkbox"/> Other Chronic Condition
	<input type="checkbox"/> Other
	<input type="checkbox"/> Asthma
	<input type="checkbox"/> Diabetes
	<input type="checkbox"/> Epilepsy / Seizures
	<input type="checkbox"/> Heart Conditions / Murmur
	<input type="checkbox"/> Food Allergies (specify)
	<input type="checkbox"/> Medication Allergies (specify)
	<input type="checkbox"/> Other Allergies ~ insect stings, hay fever, animal
	<input type="checkbox"/> Other (Please detail)

*** Details of above to be completed on additional sheet ***

Individualized Order Form for ALL medications MUST also be completed. This form is available on the backside of this page!

Immunization and Physical form from school / physician may be submitted in lieu of completing the immunization and physical examination section below.

Immunizations

<i>Immunizations</i>	<i>Date</i>	<i>Boosters</i>
Dtap/TD/Tdap		
Polio (3)		
Hepatitis B (3)		
MMR (2)		
TD (valid 10 y)		
Haemophilus Influenza Type B		
COVID-19		

<i>Immunizations or proof of illness</i>	<i>Date</i>
Varicela or proof of Chicken Pox	

<i>Illness (if applicable)</i>	<i>Date</i>
Measles	
German measles	
Mumps	
Hepatitis A	
Hepatitis C	

Physical Examination: - Valid for One Year Only and to Be Completed by a Licensed Health Care Professional ONLY!

Height		Weight	
Hearing (R / L)		Vision (R / L)	
Dental / Bite		Respiratory	
Cardiac		BP	
Hernia		Extremities	
Genitals		Skin	

RESTRICTIONS, LIMITATIONS (INCLUDING DIET):

RECOMMENDATIONS:

The above named person is in satisfactory condition and may engage in all camp activities except as noted:

Date: _____ Examining physician: _____

Telephone: (_____) _____

Print physician's name: _____

State licensed in: _____ License #: _____

Address: _____

Please mail original by JUNE 23, 2023 (IMPORTANT) and also bring one copy to camp:

VILLAGE OF HAMILTON
P. O. BOX 119 / 3 BROAD STREET, HAMILTON, NY 13346
Tel. 315-824-1111 SEE REVERSE SIDE * *

Individualized Order Form

CAMPER: _____ **DATE OF BIRTH:** _____ **WEIGHT:** _____ lbs.

The following form must be completed and signed by the child's physician if your child:

- Needs to take any routine Over the Counter Medications, provided by the parent/guardian, while at camp.
- Needs to take any routine Prescription Medications, provided by the parent /guardian, while at camp.

If your child needs to take any "as needed" over-the-counter medications while at camp, he or she will need to see a medical professional for a prescription.

All Medications (Prescription and Over-the-Counter)

Please complete with the camper's current regimen for both **Prescription and Over-the-Counter** medications (i.e. antibiotics, asthma inhalers, allergies, etc.).

This person takes NO medications on a routine basis.

Drug Name	Route	Dosage	Physician Order / Regimen	Comments

The following information to be completed by the camper's health care provider:

Camper's Health Care Provider Name: _____	Phone #: _____
Address: _____	License #: _____
Physician's Signature: _____	Date: _____



Parent / Guardian's Signature: _____	Date : _____
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