VILLAGE OF HAMILTON

Due back by: June 21, 2024 **Start Date: _____**
(Send the original – and also bring a copy to camp) **End Date: _____**
PLEASE COMPLETE ENTIRE FORM!

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:

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

*** * * 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

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

Immunizations or proof of illness	*Date*
Varicela or proof of Chicken Pox	

Illness (if applicable)	*Date*
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 21, 2024 (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 :_____