Town Of Hyde Park Recreation
2017 DAY CAMP MEDICAL HISTORY FORM

Child's Name: _____ Date of Birth: _____

Age: _____ Gender:__M____F_____ Camps/Week(s): _____

Parent/Guardian: _____

Address: _____

Home Phone #: _____ Work Phone #: _____

Cell Phone #: _____E-mail: _____

Emergency Contact Information:

Name: _____ Relationship to Camper: _____

Address: _____

Phone #: _____ e-mail: _____

Physician's Information:
Name of Physician _____Office Phone #:_____

Family Medical/Hospital Insurance Carrier: _____

Policy or Group #: _____

Please Read and Sign:

This health history and information is correct as far as I know. The person herein described has permission to engage in all camp activities, except as noted. In the event I cannot be reached in an emergency, I hereby give permission to medical personnel selected by the camp director to order x-rays, routine tests, to hospitalize, secure proper treatment for and to order injections or anesthesia and/or surgery for my child as named above.

I, _____, do hereby recognize the risks of illness and injury inherent during the time of the use of The Town of Hyde Park recreational facilities. Therefore, I do hereby, for myself, my heirs, executors and administrators, waive and release any and all rights and claims for damages I and/or my guests and participants may have against the Hyde Park Recreation Department, their agents, representatives, successors and assigns for any all injuries suffered by the undersigned and his/ her guests and participants during this event.

Signature: _____

Date: _____

HEALTH HISTORY

See Reverse

Do you have or are subject to any of the following:

___ Asthma
___ Bleeding Disorder
___ Fainting Spell
___ Hay Fever
___ Mental Condition
___ Seizures
___ Swimming Restrictions
___ Allergy or Drug Reaction
___ Bee Sting Reaction
___ Diabetes
___ Ear Infections
___ Heart Disease/Defect
___ Poison Ivy Sensitive
___ Sports Restriction
___ Allergies
___ Dietary Restriction

Please explain any of the above: _____

If female: _____ Started Menstruation. If no, has been told about it? _____

Provide dates of the following if you have had:

_____ Measles _____ Mumps _____ Chicken Pox

_____ German Measles _____ Mononucleosis _____ Diphtheria

Any operations or serious injuries:
(Include Dates) _____

Any Disability or Chronic Illness: _____

Any restriction of activity for medical reasons: _____

Please list all required medication, including over the counter medications:
(Include specific dose)

Are there any medications that will need to be dispensed during camp hours? If so, please list. You must attach a doctor's note authorizing administration by camp personnel.

Please attach to this form, the most recent immunization record for this individual.