GSB Day Camp
Health History Form

Campers will not be admitted to camp without a completed medical form.

Please mail this form by June 1st to:
GSB Day Camp
PO Box 604
Gladstone, NJ 07934 - 0604

Name _____ Birth Date_____/_____/_____ Age at the start of camp **(6/24/2024)**

_____ Gender: Female_____ Male_____ Non Binary _____ Other _____

Home Address _____

Street **City** **State** **Zip**

Custodial parent/guardian _____ Phone_____

Home Address _____

Street **City** **State** **Zip**

Business Address _____

Street **City** **State** **Zip**

Second parent or guardian or emergency contact _____ Phone_____

Home Address _____

Street **City** **State** **Zip**

Business Address _____

Street **City** **State** **Zip**

Physician's Name _____ Physician's Phone Number_____

Date of the most recent physical exam (month/year) _____ **(must have current physical w/in past 12 months)**

Is the participant covered by family medical/hospital insurance? ☐Yes ☐ No

Is so, indicate carrier or plan name _____ Group#_____

Photocopy of front and back of health insurance card must be attached to this form.

Please indicate any allergies in the following categories.

Medication_____

Food_____

Other_____

Please explain if the camper has any restrictions to activity while at camp_____

_____

Please explain any dietary restrictions that your child may have_____

_____

_____

_____

Please check all that apply. The camper has/does:

- ☐ a recent injury, illness or infectious disease?
- ☐ a chronic or recurring disease?
- ☐ Frequent headaches?
- ☐ Had surgery?
- ☐ Nose or sinus problems?
- ☐ Frequent ear infections?
- ☐ Frequent eye infections?
- ☐ Glasses or corrective lenses?
- ☐ Passed out due to exercise?
- ☐ Been dizzy during exercise?
- ☐ Wear braces?
- ☐ Had seizures?
- ☐ Had a head injury?
- ☐ Problems with joints?
- ☐ Skin problems?
- ☐ Diabetes?
- ☐ Asthma?
- ☐ An eating disorder?
- ☐ Behavioral Conditions?
- ☐ Problems with diarrhea or constipation?
- ☐ Heart problems? (High BP, murmur?)

Please explain any checked statements below. _____

In the event of minor medical emergency or illness, the Camp Nurse has my permission to administer the following OTC medications.

☐Tylenol (Acetaminophen) ☐ Benadryl ☐ Antibiotic Ointment ☐ Advil (Ibuprofen) ☐ Bug Spray

Please give all dates of immunizations for the following:

Vaccine: Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP						
TD (tetanus/diphtheria)						
Tetanus						
Polio						
MMR						
Or Measles						
Or Mumps						
Or Rubella						
Hemophilia influenza B						
Hepatitis B						
Varicella (chicken pox)						

Which of the following has the participant had?

- ☐ Measles
- ☐ Chicken Pox
- ☐ German Measles
- ☐ Mumps
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C

Please list any other additional information that would be helpful to ensuring the best care for your child this summer. Please include any physical, emotional, or mental health information about which GSB Day Camp should be aware. _____

To the best of my knowledge this Health History is correct and complete. The camper has permission to participate in all camp activities unless otherwise noted on this form.

I hereby give permission to **GSB Day Camp** to provide, seek, and consent to routine medical health care, administration of prescribed medications, and emergency treatment for my child as may be necessary. This includes, but is not limited to: x-rays, routine tests and treatment, and/or hospitalization. I give permission to GSB Camp to provide transportation required for treatment. I understand that all medical bills for services to my child rendered by anyone other than the GSB Camp staff are my responsibility. I agree to release any records necessary for treatment, billing, or insurance purposes.

It is my intention that the camp be treated as acting *in loco parentis* for my child. If I cannot be reached in the event of an emergency, I grant permission to **GSB Camp** to use the physician they have selected to secure treatment, including hospitalization.

Signature of Parent/Guardian _____Printed Name_____ Date_____

**Medication Permission and Physician Instruction

Camper Name _____ Date of Birth _____

Address: _____

Street **City** **State** **Zip**

Parent/Guardian Permission:
I give permission to the camp nurse, or those adults authorized in her absence to administer the medications(s) listed below.

Parent Name _____Home Phone: _____Work Phone _____

Parent Signature _____ Date _____

……

Medication _____

Dose: _____Frequency: _____

Diagnosis _____

Cautionary Information specific to this medication (Side effects, sensitivities, etc.)

_____

_____

Medication _____

Dose: _____Frequency: _____

Diagnosis _____

Cautionary Information specific to this medication (Side effects, sensitivities, etc.)

_____

_____

Physician's Signature_____

****Note: All Medications must be supplied in their original containers with attached prescription or signed instructions from prescribing physician. Any prescriptions not picked up at the end of camp (8/16/2024) will be destroyed.**