



# GSB Day Camp Health History Form

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

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

Name \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Age at the start of camp (6/22/2026)  
\_\_\_\_\_ 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:**

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

**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 (8/14/2026) will be destroyed.**