



Hammel Tennis Camp
 524 Boston Post Rd Wayland MA 01778
 508-358-7355

CAMPER HEALTH FORM

SECTION ONE - To be filled out by PARENT or GUARDIAN

DATE: _____

NAME: _____ (FIRST) _____ (LAST)

DATE OF BIRTH: _____ AGE: _____ SEX: _____

PARENT/GUARDIAN: _____

ADDRESS: _____ TOWN: _____ ZIP: _____

HOME TEL.#: _____ WORK#: _____

CELL PHONE/BEEPER#: _____

Does Your Child Need a Floatie to Swim (Yes or No) _____

IN AN EMERGENCY, NOTIFY: (other than parents)

Can this person pick up your child?
 (Please circle)

1. _____ PHONE#: _____ Yes No

2. _____ PHONE#: _____ Yes No

People MUST live close by and know they are listed as emergency contact

CAMPER COVERED BY HEALTH INSURANCE: YES _____ NO _____

CARRIER: _____ POLICY# _____

PLEASE CHECK ALL THAT APPLY WITH DATES (if possible):

FREQUENT COLDS _____ CHICKEN POX _____

SORE THROATS _____ POLIO _____

SINUS/EAR INFECTIONS _____ MEASLES _____

ASTHMA/BRONCHITIS _____ MUMPS _____

FAINTING _____ RUBELLA _____

STOMACH PROBLEMS _____ WHOOPING COUGH _____

RHEUMATIC FEVER _____ MENSTRUAL PROBLEMS _____

HEART PROBLEMS _____ HEADACHES _____

DIABETES _____ ATHLETES FOOT _____

EPILEPSY/SEIZURES _____ BOWEL/BLADDER PROBLEMS _____

TUBERCULOSIS _____ OTHER: _____

ANY OTHER HEALTH PROBLEMS/ISSUES/HANDICAPS OR SPECIAL PRECAUTIONS?

ANY ACTIVITY OR DIET RESTRICTIONS? _____

ALLERGIES:

MEDICATIONS: _____

BEE STINGS: _____ FOODS: _____

OTHER: _____

MEDICATIONS TAKEN ON A REGULAR OR AS NEEDED BASIS:

NAME OF MEDICATION: _____

DOSAGE: _____

FREQUENCY: _____ SIDE EFFECTS ETC. _____

Will this medication be taken at home or at camp? _____

I hereby give my permission for my son/daughter _____ to take/have administered the medication(s) noted above. I understand that all medications, prescriptions and/or over the counter, must be in their original containers, must be labeled and have specific directions for use on the label. A prescription medication must include: - the prescription number, medication name, date filled and expiration date, child's name, doctor's name, pharmacy name.

PARENT/GUARDIAN _____ DATE: _____

IN CASE OF A MEDICAL EMERGENCY:

I understand every effort will be made to contact parents/guardians of campers. In the event that I can not be reached, I hereby give my permission for the following: The Physician selected by the Camp Director may secure proper treatment for, hospitalization, order and administer medications and anesthesia, perform x-rays, special procedures, or surgery if deemed medically necessary by him/her for my child.

PARENT/GUARDIAN _____ DATE: _____

CAMPER HEALTH FORM

SECTION TWO - To be filled out by your child's Physician

OR attach a copy of your child's last well check up form.

CAMPER'S NAME: _____

MANDATORY IMMUNIZATIONS

Child may not attend camp without this information

DPT Series (4): _____

Td Booster if >10 years since last DPT _____

MMR Series: (2) if k-7 (1) if 3-pre K _____

Polio Series (at least 3) _____

TB skin Test Date(optional): _____

HEP B: _____

Any Handicaps/Special Precautions/Restrictions or Concerns?

Overall State of Health:

Allergies to foods, bees, medications or other?

Print Physicians Name: _____

Signature: _____

Address: _____

DATE: _____

Telephone #: _____ License#: _____