GATE HILL DAY CAMP

"Where memories are made one smile at a time."

PO BOX 592, GATE HILL ROAD, STONY POINT, NY 10980
(845) 947-3223

STAFF MEDICAL FORM

Name ___________________________________ Birth Date ___________ Sex ______ Age____
Last First MI

Parent or Guardian ____ Phone_______________
Area Code + Number

Home Address ____
Street & Number Apt# City State Zip Code

Business Address ____Phone_____________
Street & Number Apt# City State Zip Code Area Code + Number

Second Parent or Guardian or Emergency Contact __________________ Relationship________

Home Address ____
Street & Number Apt# City State Zip Code

Business Address ____Phone_____________
Street & Number Apt# City State Zip Code Area Code + Number

If those named above are not available in an emergency, notify:

Name ___________________________ Relationship ____________ Phone ___________
Area Code + Number

Address ____
Street & Number Apt# City State Zip Code

HEALTH HISTORY: to be filled in by adult staff members or parent/guardian or minors (approx. dates)

Ear Infections________ Convulsions_____ Insect Stings_____ Measles______

Heart Defect _______ Diabetes_______ Penicillin Allergy___ Mumps______

Rheumatic Fever____ Hay Fever______ Drug Allergy_____ Poison Ivy___

Clot Disorders______ German Measles___ Chicken Pox_____ Asthma______

Operations/Serious Injuries (Dates): ____

Disability or chronic/recurring illness: ____

Any specific activities to be encouraged or limited by physician's advice: ____________________
____

Dietary Modifications: ____

Current medications (Send with enclosed instructions):___________________________________
____

IMMUNIZATION HISTORY: Please record the date (month/year) of basic immunizations/boosters

DTP Series________________ Booster__________________ Tetanus Boosters____________
Polio OPV (Sabin) ___________ Booster__________________ Tuberculin Booster___________
Measles (Date of 1st)_________ 2nd or MMR______________ Mumps (Live) ______________
German Measles______________________________ Date of Last Tetanus Shot ___________

PLEASE COMPLETE REVERSE SIDE

IMPORTANT: Please notify the camp if exposed to any communicable diseases during the three weeks prior to starting camp.

Name of dentist: ___________________________________ Phone: ____________________

Name of family physician: ___________________________ Phone: _____________________

Do you carry family/hospital insurance? Y/N If so, indicate: Carrier __________ Policy# ______

*If you require hospital care you will be taken to either Nyack Hospital or Good Samaritan Hospital.

Special Considerations: ____

Authorization:
This health history is correct, so far as I know. In the event of an EMERGENCY, I hereby give permission, so the physician selected by the camp director, to hospitalize and secure proper treatment and to order injection, anesthesia, or surgery for myself as named above

Permission to Participate and Assumption of Risk:
I understand that all camp activities and interactions present the possibility of accidental injury to staff members. These accidents sometimes occur in spite of Gate Hill's risk management efforts. I have read the camp brochure/staff manual and I am aware of all the camp activities.

No staff member may attend Gate Hill without a physician signed medical form indicating up-to-date immunization. (This is a Rockland County Board of Health Mandate.)

Signature of Staff Member:____
Signature of parent/guardian if staff member is a minor:___________________________
Date:_________________

HEALTH EXAMINATION BY LICENSED PHYSICIAN: This examination should be performed within 12 months of arrival at camp. Examination is for determining fitness to engage in activities.

I have examined the above applicant. Date examined: _______________________
In my opinion, the above persons condition does _____/does not _____ preclude his/her participation in an ACTIVE camp program (sports, swimming, hiking)

Code: V=Satisfactory X=Not Satisfactory (explain) O=Not Examined

Height_______ Weight______ B.P._______ Hgb. Test ______ Urinalysis______
Eyes ______________________ Hernia___________________ Glasses____________________
Extremities_________________ Ears_____________________ Posture (spine)______________
Nose______________________ Skin_____________________Throat______________________
Allergy____________________ Hearing__________________ Lungs______________________
Abdomen__________________
This applicant is under the care of a physician for the following conditions(s):_________________
____

Current treatment (include current medications):____
____

Explanation of any reported loss of consciousness, convulsions, or concussions: _______________
____

Does applicant have epilepsy? Yes__ No___ Does the applicant have diabetes? Yes___No___
Recommendations and Restrictions while at camp:
Any treatment to be continued at camp:____
Any medication to be administered at camp (specific dosages):_____________________________
Any medically prescribed meal plan or dietary restrictions:__________________________________
____
Any allergies (Food, drugs, plants, insects, etc) ____
Additional Health Information Licensed Physicians Names: _____________________________
Licensed Physician's Signature _______________________________ Phone___________________
Address____
Date of completion ___________________ *By ______________________________________
**If completed by nurse or physicians assistant, please initial.*