WINSTON DAY CAMP MEDICAL INFORMATION RECORD

Camper's Name ____ Sex____

Date of Birth:________________ Age____ Weight____ Height_____

IMMUNIZATION RECORD

please be sure to fill out all dates:

1) *4 doses of HAEMOPHILUS INFLUENZA TYPE B VACCINE______*
2) *3 or more doses of DIPHTHERIA TOXOID______________*
3) *3 or more doses of ORAL POLIO VACCINE_____________*
4) *3 doses of HEPATITIS B VACCINE________*
5) *1 dose of LIVE MUMPS VACCINE_________*
6) *1 dose of LIVE MEASLES VACCINE_______*
7) *1 dose of LIVE RUBELLA VACCINE_______*
8) *1 dose of VARICELLA (Chicken Pox) Vaccine_________*
9) *HAEMOPHILUS INFLUENZA TYPE B __________*
10) *HEPATITIS B _______________*

LAST TETANUS BOOSTER___________

HEALTH HISTORY

ALLERGIES- MEDICATION:

ASPIRIN_________ PENICILLIN________ OTHER_________

ALLERGIES- OTHER (include insect or bee stings)

. . . .

PHYSICAL HISTORY

(Please explain yes answers.)

ANY RECENT INJURY, ILLNESS,OR INFECTIOUS DISEASE: Yes No

CHRONIC OR RECURRING ILLNESS/CONDITION: Yes No

HEART MURMUR: Yes No
ASTHMA: Yes No
HEADACHES: Yes No

ORTHOPEDIC PROBLEMS: Yes No
WEAR GLASSES OR CONTACT LENSES: Yes No (if so, when)
STOMACH PROBLEMS: Yes No

EMOTIONAL PROBLEMS,OR FEARS: Yes No

Please note any comments pertaining to the physical or emotional well being of the camper that would be helpful to the medical staff:

Food Allegies: Please explain.

Does Not Eat: Meat_____Poultry_____Dairy_____Other_____

WILL CAMPER BE BRINGING ANY MEDICATION TO CAMP: Yes No

Name of medication: Reason For: Dosage

Has child ever had:
CHICKEN POX: Yes No Date:________
HEAD LICE: Yes No Date(s)______
....

TO BE FILLED OUT BY CAMPER'S PHYSICIAN:

I have examined the above named camper. In my opinion,this child is physically able to enter into all camp activities.
Child has the following restrictions:_______(please list)
Date of most recent physical examination:_______
Physician's Name:_____________
Address:

Telephone Number:

Physician's Signature____________

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INSURANCE INFORMATION

FAMILY MEDICAL/HOSPITAL INSURANCE NAME:
GROUP NUMBER:
CARRIER ADDRESS:
NAME OF INSURED:
....***In the event of an emergency, Winston Day Camp, Inc., is authorized to have x-rays taken, administer medication, order routine tests , use medical and dental specialists, and any care considered essential to the health and well being of my child.***

____
Parent /Guardian Signature Date

If parents cannot be contacted: EMERGENCY NAME AND NUMBER

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