

**IVY LEAGUE DAY CAMP**

732-446-7035 phone  
732-446-5623 fax

140 Gordons Corner Road  
Manalapan, NJ 07726

Camper Grade \_\_\_\_\_  
Next September \_\_\_\_\_

**PERSONAL HEALTH AND MEDICAL FOR CAMPER**

Directions: Parent or Guardian: Please complete BOTH SIDES of this form. A doctor does not have to complete form.

Camper \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Home Phone \_\_\_\_\_

Mother/Guardian Name \_\_\_\_\_ Business ( ) \_\_\_\_\_ Cell ( ) \_\_\_\_\_

Father/Guardian Name \_\_\_\_\_ Business ( ) \_\_\_\_\_ Cell ( ) \_\_\_\_\_

**IN AN EMERGENCY PLEASE NOTIFY** (someone close to Camp who is available during the day)

1. Name _____	2. Name _____
Address _____	Address _____
City & State _____	City & State _____
Relationship _____	Relationship _____
Home Phone _____	Home Phone _____
Other Phone _____	Other Phone _____

Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Dentist's Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Do you carry family medical/hospital insurance? No \_\_\_ Yes \_\_\_ indicate carrier \_\_\_\_\_

Policy or group \_\_\_\_\_ Social Security # of Policy Holder \_\_\_\_\_

**IMMUNIZATIONS** (must be completed each year as required by the State) **PLEASE ATTACH MOST RECENT COPY OF IMMUNIZATIONS OR FILL OUT IMMUNIZATION RECORD FORM**

**Attach small, recent photo here:**

**MEDICAL HISTORY**

Date of most recent physical exam (month and year) \_\_\_\_\_

Is camper currently under medical care?  No  Yes (explain) \_\_\_\_\_

Has there been any surgery, illness, allergy or change in health status since the last complete physical exam? No \_\_\_\_\_

Yes \_\_\_\_\_ Explain \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Does your child require an Epi-Pen®? YES \_\_\_\_\_ NO \_\_\_\_\_

Has your child ever needed an Epi-Pen® administered? YES \_\_\_\_\_ NO \_\_\_\_\_

**CHECK ALL THAT CURRENTLY APPLY: (Explain in the space below)**

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Significant Life Changing Event | <input type="checkbox"/> Deficit Disorder(ADD or AD/HD) | <input type="checkbox"/> Behavioral, Emotional Difficulties | <input type="checkbox"/> Eyes, Contacts, Glasses |
| <input type="checkbox"/> Heart                           | <input type="checkbox"/> Surgery                        | <input type="checkbox"/> Immune Deficiency                  | <input type="checkbox"/> Seizures                |
| <input type="checkbox"/> Back, Limbs, Joints             | <input type="checkbox"/> Nose, Sinus, Tonsils           | <input type="checkbox"/> Teeth, Braces                      | <input type="checkbox"/> Diabetes                |
| <input type="checkbox"/> Stomach, Bowels                 | <input type="checkbox"/> Ears, Hearing Aids             | <input type="checkbox"/> Menstrual Problems                 | <input type="checkbox"/> Other                   |
| <input type="checkbox"/> Kidneys, Urine                  | <input type="checkbox"/> Skin, Glands                   | <input type="checkbox"/> Physical Disability                |  |
| <input type="checkbox"/> Chest, Lungs (Asthma)           | <input type="checkbox"/> Hernia                         | <input type="checkbox"/> Fainting Spells                    |  |
| <input type="checkbox"/> Allergies                       | <input type="checkbox"/> Serious Illness/ Injury        | <input type="checkbox"/> High Blood Pressure                |  |

**Explain** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Approved for Participation in all activities including competitive sports and water activities.**

Yes \_\_\_\_\_ No \_\_\_\_\_

**If no, please explain any restrictions**

\_\_\_\_\_  
\_\_\_\_\_

**Treatment**

In the event of a minor medical emergency, the Camp Nurse has my permission to administer the following over-the-counter medications according to the label instructions, at her discretion:

Chloroseptic Spray No \_\_\_ Yes \_\_\_      Acetaminophen (Tylenol) No \_\_\_ Yes \_\_\_      Tums No \_\_\_ Yes \_\_\_

Benadryl Spray No \_\_\_ Yes \_\_\_      Benadryl Elixir Tablets No \_\_\_ Yes \_\_\_

**Medical Authorization**

I, \_\_\_\_\_, parent or guardian of \_\_\_\_\_

authorize any physician, nurse or other health care provider, to communicate with the medical staff and director of **Ivy League Day Camp**, or their designee, about my child's medical condition, treatment, and/or prognosis. I give permission for an Ivy League Day Camp Staff member to administer an emergency Epi-Pen® if deemed necessary.

I further authorize the camp medical staff to discuss any medical conditions with the director, his/her designee, or the child's counselor when the medical staff, in its sole discretion, believes such communication to be in the best interest of the child.

To the best of my knowledge, the medical history is correct and complete. I know of no reason to restrict my camper's activity and give my permission for participation in all activities except as specifically noted herein. In the event I cannot be reached in an EMERGENCY, I hereby give permission to the Physician selection by the Camp Director to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child as named above.

Date: \_\_\_\_\_

\_\_\_\_\_  
Parent or Legal Guardian