CAMP SKYLANDS HEALTH FORM

CHILD

NAME:	BIRTH DATE:	GENDER: M | F
DO BOTH PARENTS LIVE WITH THE CHILD? Y | N	MAY EITHER PARENT PICK UP CHILD AT ANY TIME? Y | N	

PARENT/GUARDIAN

NAME:		RELATIONSHIP:
ADDRESS:		HOME PHONE:
CITY:		WORK PHONE:
STATE:	ZIP:	OTHER PHONE:

PARENT/GUARDIAN

NAME:		RELATIONSHIP:
ADDRESS:		HOME PHONE:
CITY:		WORK PHONE:
STATE:	ZIP:	OTHER PHONE:

EMERGENCY CONTACT #1

NAME:		RELATIONSHIP:
ADDRESS:		HOME PHONE:
CITY:		WORK PHONE:
STATE:	ZIP:	OTHER PHONE:
IN THE EVENT OF MY ABSENCE, MAY THIS PERSON CARE (PROVIDE EMERGENCY & NON-EMERGENCY TRANSPORT) FOR MY CHILD: Y | N		

EMERGENCY CONTACT #2

NAME:		RELATIONSHIP:
ADDRESS:		HOME PHONE:
CITY:		WORK PHONE:
STATE:	ZIP:	OTHER PHONE:
IN THE EVENT OF MY ABSENCE, MAY THIS PERSON CARE (PROVIDE EMERGENCY & NON-EMERGENCY TRANSPORT) FOR MY CHILD: Y | N		

If a non-custodial parent is not included among those persons authorized by the custodial parent to pick up the child, please explain below and attach a copy of the appropriate documents such as a court order, etc.

.....

.....

.....

DEAR SUMMER CAMP PARENT,

All parts of this Health Form must be completed and returned to the Skylands Summer Camp Health Office at least 1 week prior to arrival on campus. It is advised, prior to mailing these forms, that you make a copy to hand carry to the camp on the child's first day. No camper will be allowed to stay without completed health forms.

IMPORTANT NOTES:

PHYSICAL EXAMINATION: A physical examination must also be completed and returned to the Camp Health Office prior to arrival on campus. School and Sport physicals are expectable assuming they are within expiration (cannot be older than one (1) year as of September 2014). If you do not have a physical form already, you can use the last page of this packet for your doctor to fill out.

IMMUNIZATION RECORD: Please submit a copy of your child's current immunization record. If you have any questions about which immunizations are needed in order to attend summer camp please call the camp office.

MEDICATIONS: Please fill out the medication section of the form with the current medications that the camper will be taking at camp. All medication requires a physician's note (RX) to be on file. NO medication will be administered without proper verifications. All prescription and over- the-counter (OTC) medications to be taken by a camp participant must be left and kept at the Skylands Summer Camp Health Office where the Health Director will set up for the dispensing of the medication. All medication must be in the pharmacy bottle or original store container with proper labeling.

Please be sure to sign and date page 5. If this page is not signed the camper will not be allowed to stay at camp for the day.

For any medical questions, please call the Skylands Summer Camp Health Office at (973) 697-1600 ext 128.

CAMP SKYLANDS HEALTH FORM

INSURANCE INFORMATION

IS CHILD COVERED BY MEDICAL/HOSPITAL INSURANCE: Y | N	**PRESCRIPTION PLAN: Y | N**
IF SO, INDICATE CARRIER OR PLAN NAME:	GROUP NUMBER:
CARRIER'S ADDRESS:	
NAME OF INSURED:	RELATIONSHIP TO CHILD:
***PLEASE PROVIDE A COPY OF ANY/ALL HEALTH INSURANCE CARD(S) IN THE CASE OF AN EMERGENCY.**	
PERSONAL PHYSICIAN:	PHYSICIAN TYPE:
OFFICE PHONE:	ADDRESS:

HEALTH HISTORY

The following must be filled out by the parent / guardian. The intent of this information is to provide health care personnel the background to deliver appropriate care. All campers MUST have a physical examination on file with the camp from their personal health care professional (licensed in the State of New Jersey to perform physical examinations.) School physicals are expectable as long as they are within expiration (must last the entire summer and cannot be older than one (1) year). A current immunization record is needed as well.

ALLERGIES:

PLEASE CHECK YES OR NO	LIST ALL	DESCRIBE REACTIONS & MANAGEMENT OF THE REACTION
MEDICATION ALLERGIES: Y | N		
FOOD ALLERGIES: Y | N		
OTHER ALLERGIES: Y | N		

MEDICATIONS: ATTACH ADDITIONAL PAGES FOR MORE MEDICATIONS.

ARE THERE ANY MEDICATIONS THAT NEED TO BE TAKEN AT CAMP? Y | N	
NAME OF MEDICATION #1:	DOSAGE:
SPECIFIC TIMES TAKEN EACH DAY:	REASON FOR TAKING MEDICATION:
NAME OF MEDICATION #2:	DOSAGE:
SPECIFIC TIMES TAKEN EACH DAY:	REASON FOR TAKING MEDICATION:

GENERAL QUESTIONS

HAS/DOES THE CHILD?	YES	NO
1. HAD ANY RECENT INJURY, ILLNESS OR INFECTIOUS DISEASE?		
2. HAVE A CHRONIC OR RECURRING ILLNESS/ CONDITION?		
3. EVER BEEN HOSPITALIZED?		
4. EVER HAD SURGERY?		
5. EVER HAD A HEAD INJURY?		
6. HAVE FREQUENT HEADACHES		
7. EVER BEEN KNOCKED UNCONSCIOUS?		
8. WEAR GLASSES, CONTACTS OR PROTECTIVE EYE WEAR?		
9. EVER HAD FREQUENT EAR INFECTIONS?		
10. EVER HAD SEIZURES?		
11. EVER BEEN DIAGNOSED WITH A HEART MURMUR?		
12. EVER HAD PROBLEMS WITH JOINTS?		
13. EVER HAD BACK PROBLEMS?		
14. HAVE AN ORTHODONTIC APPLIANCE BEING BROUGHT TO CAMP?		
15. HAVE ANY SKIN PROBLEMS?		
16. HAVE DIABETES?		
17. HAVE ASTHMA?		
18. HAD MONONUCLEOSIS IN THE PAST 12 MONTHS?		
19. HAD PROBLEMS WITH DIARRHEA/ CONSTIPATION?		
20. HAVE PROBLEMS WITH SLEEPWALKING?		
21. HAVE A HISTORY OF BED-WETTING?		
22. EVER HAD EMOTIONAL DIFFICULTIES FOR WHICH PROFESSIONAL HELP WAS SOUGHT?		

PLEASE EXPLAIN ANY "YES" ANSWERS, NOTING THE NUMBER OF THE QUESTIONS.

PLEASE LIST ANY PHYSICAL / MENTAL LIMITATIONS THAT THE PARTICIPANT HAS:

CAMP SKYLANDS HEALTH FORM

PARENTAL PERMISSION SLIP

In an emergency, I hereby give permission to the camp to provide, seek, and consent to routine health care, administration of prescribed medications, and emergency treatment for my child, while at Skylands Ice World's Camp Skylands, as may be necessary, including, but not limited to, x-rays, routine tests and treatments, medical examinations, emergency drug therapy, and/or hospitalization. I also give my permission for the camp director to arrange related transportation. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.

I hereby give permission to the Camp Health Director to administer to my minor child named above the prescription and/or non-prescription medications accompanying then to camp. I give permission for the camp's medical staff to administer basic first aid and care as prescribed by the Camp's On-Call Physician. I understand that the Health Director will not administer any medications by injection unless for emergency purposes (epi-pens, insulin, ect).

The person herein named above has permission to engage in all camp activities except as noted in the Health History Form. It is my intention that the Camp Health Director be treated as acting in loco parentis of the person herein named is a minor.

Further, it is my intention that the appropriate representatives of the camp be treated as "personal representatives" for the purpose of disclosing protected health information pursuant to the privacy regulations promulgated to the Health Insurance Portability and Accountability Act of 1996. I hereby agree (pursuant to 45 CFR 164.510(b)) to the disclosure to camp representatives of the protected health information of the person herein described, as necessary: (i) to provided relevant information to the Camp Director and Health Director related to the person's ability to participate in camp activities; and (ii) in the case of minor injury to provide relevant information to the camps director to keep me informed of my child's health status.

In the event that I cannot be reached in an emergency, I hereby give permission to the Camp Health Director and the selected physician to secure and administer treatment, including but not limited to hospitalization, for the person named above. This completed form may be photocopied for trips and out of camp activities.

I understand and agree that Skylands Ice World (SIW) shall in no way be responsible, or in any way be liable, for any injury, claim for damages, pain and/or suffering, or any liability whatsoever arising out of camper's use of, or presence at, SIW at any time. I acknowledge that all activities offered at SIW, including those incidental in nature, contain inherent elements of risk which the parent fully accepts and agrees to bear the full burden of. It is my intention to forever waive and release SIW from any claims of any kind whatsoever, in law or in equity, on account of any injury or other damages of any kind, including but not limited to loss of personal property while on SIW premises, or while coming to or from SIW. I hereby also grant to SIW the right to use any photographic or video images taken of the camper while at SIW for use for SIW for advertising and/or promotional and marketing purposes.

This health history is correct and complete as far as I know.

SIGNATURE OF PARENT/ LEGAL GUARDIAN: .....

PRINTED NAME: .....

DATE: .....

CAMP SKYLANDS HEALTH FORM

PHYSICAL EXAMINATION FORM | Please have this completed by Health Care Provider

CHILD'S NAME:		**BIRTH DATE:**	
SEX:	AGE:	HEIGHT:	WEIGHT:
BLOOD PRESSURE:	PULSE:	ALLERGIES:	
VISION: RIGHT 20/	LEFT 20/	CORRECTED: RIGHT 20/	LEFT 20/
COLOR VISION:		HEARING: RIGHT	LEFT

CLINICAL EVALUATION

	NORMAL	ABNORMAL	NOTES/DETAILS
1. SKIN (SCARS, TATTOOS)			
2. EARS			
3. HEAD/EYES			
4. NOSE			
5. THROAT/ NECK			
6. MOUTH/TEETH			
7. LYMPHATIC			
8. CHEST/BREAST			
9. HEART			
10. LUNGS			
11. ABDOMEN (INCLUDING HERNIA)			
12. ENDOCRINE			
13. ALLERGIC/IMMUNOLOGIC			
14. GENITO/ URINARY			
15. RECTAL/ PELVIC			
16. EXTREMITIES (STRENGTH, ROM)			
17. SPINE/ OTHER MUSCULO/SKELETAL			
18. NEUROLOGIC			
19. PSYCHIATRIC			
ADDITIONAL COMMENTS:			

	YES	NO
CLEARANCE FOR ATHLETICS (INTERCOLLEGIATE AND INTRAMURAL/CLUB)		
CLEARANCE PENDING FURTHER EVALUATION (PLEASE COMMENT BELOW)		
CLEARANCE WITH LIMITATIONS (PLEASE COMMENT BELOW)		
NOT ABLE TO PARTICIPATE IN ATHLETICS		
COMMENTS		

EXAMINING HEALTH CARE PROVIDER (PLEASE PRINT):

SIGNATURE DATE:

ADDRESS: PHONE: FAX: