Camper Medical Form
Summer - 2017

Iona College Day Camps
715 North Avenue
New Rochelle, NY 10801

Gender: ☐ Male ☐ Female

Birth Date: _____

Age at Camp: _____

Last Name:_____First Name: _____M.I.:_____

Home Address: _____ City:_____ State: _____Zip: _____

Custodial Parent/Guardian: _____

Cell Phone:_____ Home Phone: _____ Business Phone _____

Home Address: _____ City:_____ State: _____Zip: _____

Business Address:_____ City:_____ State: _____Zip: _____

Second Parent/Guardian/Emergency Contact *(Please Circle One):* _____

Cell Phone:_____ Home Phone: _____ Business Phone _____

Home Address: _____ City:_____ State: _____Zip: _____

Business Address:_____ City:_____ State: _____Zip: _____

If above not available in an emergency, notify: _____

Relationship: _____

Cell Phone:_____ Home Phone: _____ Business Phone _____

Address: _____ City:_____ State: _____Zip: _____

Insurance Information

Is the participant covered by family medical/hospital insurance? ☐ Yes ☐ No

If so, indicate carrier or plan name _____ Group #_____Phone# _____

ALLERGIES List all Known.

Describe reaction and management of the reaction

Medical Allergies (list)

_____ _____

_____ _____

_____ _____

Food Allergies (list)

_____ _____

_____ _____

_____ _____

Other Allergies (list)

_____ _____

_____ _____

_____ _____

Use this space to provide any additional information about the participant's behavior, physical, emotional, or mental health about which the camp should be aware. Please be assured that all information provided on this form will be kept confidential.

_____

_____

_____

ALL MEDICATIONS BEING TAKEN: Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely.

☐ This person takes **NO** medications on a routine basis.

☐ This person takes medications as follows.

Medication 1: _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Medication 2: _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Medication 3: _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Attach additional pages for more medication listings.

Identify any medications taken during the school year that the participant does/may not take during the summer: _____

_____

GENERAL QUESTIONS: (explain any "yes" answers below)

	Has/does the participant:	Yes	No
1	Had a recent injury, illness or infectious disease		
2	Had a cronic or recurring illness/condition		
3	Ever been hospitalized		
4	Ever had surgery		
5	Have frequent headaches		
6	Ever had a head injury		
7	Ever been knocked unconscious		
8	Wear glasses, contacts, or protective eyewear		
9	Ever had frequent ear infections		
10	Ever passes out during or after exercise		
11	Ever been dizzy durring or after exercise		
12	Ever had seizures		
13	Ever had chest pain during or after exercise		
14	Ever had high blood pressure		

		Yes	No
15	Been diagnosed with a heart murmur		
16	Ever had back problems		
17	Ever had problems with joints (e.g. knees, ankles)		
18	Have an orthdontic appliance being brought to camp		
19	Have any skin problems (e.g. itching, rash, acne, eczema)		
20	Have diabetes		
21	Have asthma		
22	Had mononucleosis in the past 12 months		
23	Had problems with diarrea/constipation		
24	If female, have any abnormal menstrual history		
25	Ever had an eating disorder		
26	Ever had emotional difficulties for which professional help was sought		

Please explain any "yes" answers, noting the question number.

_____

_____

_____

Last Medical Examination:

Date: _____

Which of the following has the participant had?

- ☐ Measles
- ☐ Chicken Pox
- ☐ German Measles
- ☐ Mumps
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C

TB Mantoux Test:

Date of Last Test: _____

Result: ☐ Positive ☐ Negative

Please give all dates of immunization
(or attach immunization form from M.D.)

Vaccine:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP						
TD (tetanus/diphtheria)						
Tetanus						
Polio						
MMR						
or Measles						
or Mumps						
or Rubella						
Haemophilus Influenza B						
Hepatitis						
Varcella (chicken pox)						

Name of family physician: _____ Phone: _____

Address: _____

Name of dentist/orthodontist: _____ Phone: _____

Address: _____