# Camper Medical Form
## Summer - 2015

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: _____