Camper Medical Form
Summer - 2019

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	☐ Yes	☐ No
2.	Had a cronic or recurring illness/condition	☐ Yes	☐ No
3.	Ever been hospitalized	☐ Yes	☐ No
4.	Ever had surgery	☐ Yes	☐ No
5.	Have frequent headaches	☐ Yes	☐ No
6.	Ever had a head injury	☐ Yes	☐ No
7.	Ever been knocked unconscious	☐ Yes	☐ No
8.	Wear glasses, contacts, or protective eyewear	☐ Yes	☐ No
9.	Ever had frequent ear infections	☐ Yes	☐ No
10.	Ever passes out during or after exercise	☐ Yes	☐ No
11.	Ever been dizzy durring or after exercise	☐ Yes	☐ No
12.	Ever had seizures	☐ Yes	☐ No
13.	Ever had chest pain during or after exercise	☐ Yes	☐ No
14.	Ever had high blood pressure	☐ Yes	☐ No
15.	Been diagnosed with a heart murmur	☐ Yes	☐ No
16.	Ever had back problems	☐ Yes	☐ No
17.	Ever had problems with joints (e.g. knees, ankles)	☐ Yes	☐ No
18.	Have an orthdontic appliance being brought to camp	☐ Yes	☐ No
19.	Have any skin problems (e.g. itching, rash, acne, eczema)	☐ Yes	☐ No
20.	Have diabetes	☐ Yes	☐ No
21.	Have asthma	☐ Yes	☐ No
22.	Had mononucleosis in the past 12 months	☐ Yes	☐ No
23.	Had problems with diarrea/constipation	☐ Yes	☐ No
24.	If female, have any abnormal menstrual history	☐ Yes	☐ No
25.	Ever had an eating disorder	☐ Yes	☐ No
26.	Ever had emotional difficulties for which professional help was sought	☐ Yes	☐ No

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:	**Month/Year**	**Month/Year**	**Month/Year**	**Month/Year**	**Month/Year**	**Month/Year**
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: _____