



# Camper Medical Form

## Summer - 2018

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)

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**Food Allergies** (list)

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**Other Allergies** (list)

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**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.**

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**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: \_\_\_\_\_

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

**Has/does the participant:**

**Yes**

**No**

- |     |  |                          |     |                          |    |
|-----|--|--------------------------|-----|--------------------------|----|
| 1.  | Had a recent injury, illness or infectious disease .....                     | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 2.  | Had a chronic or recurring illness/condition .....                           | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 3.  | Ever been hospitalized .....   | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 4.  | Ever had surgery .....   | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 5.  | Have frequent headaches .....  | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 6.  | Ever had a head injury .....   | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 7.  | Ever been knocked unconscious .....  | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 8.  | Wear glasses, contacts, or protective eyewear .....                          | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 9.  | Ever had frequent ear infections .....                                       | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 10. | Ever passes out during or after exercise .....                               | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 11. | Ever been dizzy during or after exercise .....                               | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 12. | Ever had seizures .....  | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 13. | Ever had chest pain during or after exercise .....                           | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 14. | Ever had high blood pressure .....   | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 15. | Been diagnosed with a heart murmur .....                                     | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 16. | Ever had back problems .....   | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 17. | Ever had problems with joints (e.g. knees, ankles) .....                     | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 18. | Have an orthodontic appliance being brought to camp .....                    | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 19. | Have any skin problems (e.g. itching, rash, acne, eczema) .....              | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 20. | Have diabetes .....  | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 21. | Have asthma .....  | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 22. | Had mononucleosis in the past 12 months .....                                | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 23. | Had problems with diarrhea/constipation .....                                | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 24. | If female, have any abnormal menstrual history .....                         | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 25. | Ever had an eating disorder .....  | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 26. | Ever had emotional difficulties for which professional help was sought ..... | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |

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

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**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.)

<b>Vaccine:</b>	<b>Month/Year</b>	<b>Month/Year</b>	<b>Month/Year</b>	<b>Month/Year</b>	<b>Month/Year</b>	<b>Month/Year</b>
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: \_\_\_\_\_