

# TAMARACK CAMPS CAMPER MEDICAL FORM 2010

Medical forms must be in the city office by May 1, 2010. Reverse side must be completed by physician.  
By law, this form must be completed in order for your child to attend camp.

**Camper Name** \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ M \_\_\_ F\_\_\_ Grade as of fall 2010 \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Country \_\_\_\_\_

**Primary Parent/Guardian**  
 Name/Relationship \_\_\_\_\_  
 Cell # \_\_\_\_\_ Business # \_\_\_\_\_  
 Second parent/Guardian \_\_\_\_\_  
 Name/Relationship \_\_\_\_\_  
 Cell # \_\_\_\_\_ Business # \_\_\_\_\_

Are there custodial issues in your family? If yes, to whom may the camper be released: Mother \_\_\_ Father \_\_\_ Other \_\_\_ If other, please provide name and relationship: \_\_\_\_\_

**Program (please circle):** Mini A    Mini B    Mini C    Session 1    Session 2    Super Season    TSS/Hadracha  
 Agree 1    Agree 2    Kennedy    Western 1    Western 2    Alaska

<b>Parents of 8th graders, please also check <u>Village</u>:</b>	<b>Pioneer</b>	<b>Ruach</b>	<b>Session: 1 or 2 only</b>
<b><u>OR</u>, <u>Super Season</u>:</b>	<b>Pioneer/Ruach</b>	<b>Ruach/Pioneer</b>	<b>Ruach/Ruach</b>

Please check if camper had any trouble within the last year. Explain below.

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> ADD/ADHD                    | <input type="checkbox"/> Bone/Muscle Problems  | <input type="checkbox"/> Ear Trouble          | <input type="checkbox"/> Seizures/Fainting |
| <input type="checkbox"/> Allergies                   | <input type="checkbox"/> Constipation/Diarrhea | <input type="checkbox"/> Headaches/Dizziness  | <input type="checkbox"/> Skin Problems     |
| <input type="checkbox"/> Asthma (breathing problems) | <input type="checkbox"/> Depression            | <input type="checkbox"/> Heart Trouble        | <input type="checkbox"/> Strep Throat      |
| <input type="checkbox"/> Bed wetting                 | <input type="checkbox"/> Diabetes              | <input type="checkbox"/> Nightmares/Sleepwalk | <input type="checkbox"/> Other _____       |

Explanation of above and additional medical/psychological/emotional information that is important for us to know (if necessary, please attach a separate sheet of paper):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

In case of emergency (if parent cannot be reached), additional persons to contact and to whom camper may be released:

\_\_\_\_\_ Cell # \_\_\_\_\_ Home/Business # \_\_\_\_\_  
 Name and Relationship

\_\_\_\_\_ Cell # \_\_\_\_\_ Home/Business # \_\_\_\_\_  
 Name and Relationship

**HEALTH AND SAFETY AGREEMENT:**

Camp has my permission to provide routine, non-surgical medical care to my child. In the event of a medical emergency and I cannot be reached, I hereby give permission to the physician selected by the camp director or his/her agent to hospitalize, secure treatment for, and to order injections, anesthesia or surgery for my child as named herein. I also understand that I am responsible for the costs incurred on behalf of my child relating to accident or illness when treated outside of camp. Although the fullest safety precautions are taken, the camp does not assume responsibility for any accident. I give permission to the camp director or other designated staff member to contact anyone treating the child for emotional reasons. The information obtained from such person will only be used to provide for the welfare of the child at camp. I have read all of the registration materials, policies, guidelines and details provided by the camp and agree to abide by the requirements set forth therein. I understand that my child will not be allowed to take medication from home unless it is ordered by a physician, or parent in the case of over-the-counter medication, and noted in writing on the Medication Information form. I hereby accept and agree to abide by the provisions of the Health and Safety Agreement.

\_\_\_\_\_  
**PARENT/GUARDIAN NAME (Please print)**                      **PARENT/GUARDIAN SIGNATURE**                      **DATE**



**THIS SIDE TO BE COMPLETED BY LICENSED PHYSICIAN/HEALTH CARE PROVIDER.**

Your doctor's office must complete this side of the form using the medical information from a physical examination conducted anytime between August 2008 and May 2010.

Camper Name \_\_\_\_\_ Grade as of Fall 2010 \_\_\_\_\_ Sex \_\_\_\_\_  
Birth Date \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_ Heart Rate \_\_\_\_\_

**CAMPER ALLERGIES (Please note we are not a nut-free camp. If your camper has a severe, airborne nut allergy, CAMP MAAS is not appropriate. Please be aware that peanut butter is available at meal times.):**

- None     Medications     Food     Pollens, Grasses, Trees, etc.     Other

Please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please Indicate Date:

Last Tetanus \_\_\_\_\_

Last MMR \_\_\_\_\_

Has Camper Had Chicken Pox Disease?  Yes  No  
or vaccine \_\_\_\_\_  
Date \_\_\_\_\_

Has Camper Had Menactra Meningitis Vaccine?  Yes  No  
\_\_\_\_\_ Date \_\_\_\_\_

**PLEASE ENSURE THAT ALL IMMUNIZATIONS ARE UP TO DATE BEFORE CHILD ATTENDS CAMP.**

Has the camper had any surgeries? If yes, please list dates. \_\_\_\_\_  
\_\_\_\_\_

Any restrictions or limitations camper must observe? \_\_\_\_\_  
\_\_\_\_\_

Any medical conditions camper is being treated for? \_\_\_\_\_  
\_\_\_\_\_

Presently, is camper taking any medication (including allergy) during the summer? If yes, list reason:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please indicate whether the camper has any emotional, psychological or neurological problems and explain. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(Female Campers)

Onset of Menstruation?  Yes  No    Are periods regular?  Yes  No    Painful?  Yes  No

**This information will remain confidential and will assist us in providing the camper with a quality experience.**

I have examined the above applicant for entrance to Tamarack Camps and find him/her physically qualified to be accepted as a camper and to enter into all camp activities, including canoe and extended hiking trips away from camp, except with the restrictions stated above.

Signed \_\_\_\_\_ Date of most current exam \_\_\_\_\_  
(Examining physician)