

# DRIFTWOOD DAY CAMP HEALTH HISTORY FORM 2017

Driftwood Day Camp  
331 Mount Misery Road  
Melville, NY 11747  
631-692-6990 Fax: 631-692-4140

RETURN BY March 1, 2017

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_  
Last First

Mother or Guardian: \_\_\_\_\_ Daytime #: (\_\_\_\_) \_\_\_\_\_

Cell # (\_\_\_\_) \_\_\_\_\_ Work # (\_\_\_\_) \_\_\_\_\_ Home # (\_\_\_\_) \_\_\_\_\_

Father or Guardian: \_\_\_\_\_ Daytime #: (\_\_\_\_) \_\_\_\_\_

Cell # (\_\_\_\_) \_\_\_\_\_ Work # (\_\_\_\_) \_\_\_\_\_ Home #: (\_\_\_\_) \_\_\_\_\_

Mother's Email: \_\_\_\_\_ Father's Email: \_\_\_\_\_

Address: \_\_\_\_\_  
# and Street City State Zip

Emergency Contact #1 Name: \_\_\_\_\_ Emergency Contact # (\_\_\_\_) \_\_\_\_\_

Emergency Contact #2 Name: \_\_\_\_\_ Emergency Contact # (\_\_\_\_) \_\_\_\_\_

## HEALTH HISTORY (TO BE COMPLETED BY PARENT)

Allergies to food or medication: \_\_\_\_\_

EpiPen Required? YES or NO (If yes, see EpiPen Procedure Form) Has an EpiPen been used on your child? YES or NO

Operations or serious injury: \_\_\_\_\_

Chronic or recurring illness or medical condition: \_\_\_\_\_

Daily Medications – (IF YES, MUST FILL OUT ADDITIONAL BLUE FORM). Circle One: YES or NO

As Needed Medications – (IF YES, MUST FILL OUT ADDITIONAL BLUE FORM). Circle One: YES or NO

Name of Physician \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Insurance (MUST ATTACH COPY OF CARDS): Insured Name \_\_\_\_\_ DOB \_\_\_\_\_

Policy Number \_\_\_\_\_ Name of Insurance Co. \_\_\_\_\_ Group \_\_\_\_\_

Policy Holder's Employer \_\_\_\_\_  
Name Address Phone

### Important: This box must be signed for attendance to camp.

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted on this form. **Authorization of Treatment:** I hereby give permission to the medical personnel selected by the camp director to order x-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary transportation for me/or my child. In the event that I cannot be reached in an emergency, I hereby give permission to the physicians selected by the camp director to secure and administer treatment including hospitalization, for the person named above. The completed forms may be photocopied for trips out of camp.

Signature of Parent/Guardian \_\_\_\_\_ Witness \_\_\_\_\_ Date \_\_\_\_\_

I also understand and agree to abide with the restrictions placed on my camp activities. \_\_\_\_\_

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_ Restricted Activities (Please List) \_\_\_\_\_