DRIFTWOOD DAY CAMP
HEALTH HISTORY FORM 2018

RETURN BY March 1, 2018

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

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 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. _____
Restricted Activities (Please List)