

SuperCamps at Colgate

SuperCamp Attending: _____
 Date of Camp: ____/____/____
 (Send the original – and also bring a copy to camp)
PLEASE COMPLETE ENTIRE FORM!

Student Name: _____
 Age at camp _____ Birth Date: / / Gender: M F
 Address: _____
 City: _____ State _____ Zip _____
 Phone Number (Day): _____ Evening _____
 In Case of Emergency and parent / guardian cannot be reached:
 Contact: _____
 Relationship _____ Phone: _____

Immunization and physical form from school / physician may be substituted in lieu of completing the immunization and physical examination section below

Immunizations	Date	Boosters	
Dtap/TD/Tdap			
Polio (3)			
Hepatitis B (3)			
MMR (2)			
TD (valid 10y)			
Haemophilus Influenza Type B			

Immunizations or proof of illness	Date
Varicela or proof of Chicken Pox	
Illness (if applicable)	Date
Measles	
German Measles	
Mumps	
Hepatitis A	
Hepatitis C	

Physical Examination - valid for two years only and to be completed by a licensed health care professional ONLY!

Height	Weight
Hearing (R/L)	Vision (R / L)
Dental / Bite	Respiratory
Cardiac	BP
Hernia	Extremities
Genitals	Skin

RESTRICTIONS, LIMITATIONS (including diet):

RECOMMENDATIONS:

The above named person is in satisfactory condition and may engage in all camp activities except as noted.

Date _____ Examining Physician _____
 Telephone _____
 Print Physician's Name _____
 State licensed in _____ License # _____
 Address _____

*Please mail original at least 30 days prior to camp and also bring one copy to camp: SuperCamps, PO Box 541, Canandaigua, NY 14424
 Phone (585) 394-4299. PLEASE SEE REVERSE SIDE*

Parent/Guardian Authorizations: This health history is correct and complete. The person herein described has permission to engage in all camp activities except as noted. I hereby give permission to the camp to provide routine health care and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I hereby give permission to the Director of SuperCamps or their designee to secure and administer treatment, including hospitalization, for the person named above.

Indemnification: The undersigned parent/guardian of the registrant, for and in further consideration of SuperCamps' accepting said registrant, hereby agrees to save and indemnify and keep harmless the said SuperCamps, its agents, and sponsors against any and all liability, claims, judgments, or demands arising as a result of any course of instruction or activity given the registrant by SuperCamps.

Signature of Parent/Guardian _____
 Printed Name _____ Date _____

Medical Insurance Company (REQUIRED)
 Ins. Co. _____
 Policy # _____ Group # _____
 Insured Employer _____
 We recommend that a photocopy (front and back) of health insurance card be attached to this form.

Health History: Check those that apply:	Life Threatening Conditions
<input type="checkbox"/> Contact Lenses <input type="checkbox"/> Ear Aches / Infection <input type="checkbox"/> Gyn Problems <input type="checkbox"/> Poison Ivy, Oak, Sumac <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Stomach Problems <input type="checkbox"/> Sore Throat <input type="checkbox"/> Absence of a paired organ <input type="checkbox"/> Whooping Cough <input type="checkbox"/> Sinus Problems	<input type="checkbox"/> Current orthodontic appliance <input type="checkbox"/> Mononucleosis in the past 12 months <input type="checkbox"/> Skin Problems (Acne, Eczema) <input type="checkbox"/> Recent Illness / Infections <input type="checkbox"/> HBP <input type="checkbox"/> Concussion / Head Injury <input type="checkbox"/> Other (Please detail) <input type="checkbox"/> Bone / Joint Injuries <input type="checkbox"/> Other Chronic Condition
	<input type="checkbox"/> Operations <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Epilepsy / Seizures <input type="checkbox"/> Heart Conditions / Murmur <input type="checkbox"/> Food Allergies (specify) <input type="checkbox"/> Medication Allergies (specify) <input type="checkbox"/> Other Allergies - insect stings, hay fever, animal <input type="checkbox"/> Other (Please detail)

*** Details of above to be completed on additional sheet ***

Individualized Order Form for ALL medications MUST also be completed. This form is on the reverse side of this page

Important

Individualized Order Form

CAMPER: _____ DATE OF BIRTH: _____ WEIGHT: _____

The following form must be completed and signed by the child's physician if your child:

- Needs to take any routine Prescription Medications, provided by the parent/guardian, while at camp.
- Needs to take any Over the Counter Medications "as needed," provided by the parent/guardian, while at camp.

Please Note - This form does not need to be completed or returned if your child will not be taking any medications under any circumstances during their time at camp.

Over the Counter and Prescription Medications

Please complete with the camper's current regimen for both Prescription and "As Needed" medications (i.e. antibiotics, asthma inhalers, allergies, pain relief, etc.).

This person takes **NO** medications on a routine basis.

Drug Name	Route	Dosage	Indications	Physician Order	Comments

This person has a current prescription for emergency medication (e.g., Epinephrine Pen - bee stings) Medication _____ Reason for taking _____

The following information to be completed by the camper's health care provider:

Camper's Health Care Provider Name: _____	Phone #: _____
Address: _____	License #: _____
Physician's Signature: _____	Date: _____
Parent / Guardian's Signature: _____	Date: _____