

HEALTH CERTIFICATE

Riverwood Country Day Camp

Camper's Name in Full (Please Print)

Given Name

Surname

Birthdate

Age

Sex

D

M

Y

PART 1: GENERAL INFORMATION & MEDICAL HISTORY

Tel. Home: (____) _____ Car: (____) _____ Father's Bus: (____) _____ Mother's Bus: (____) _____

Secondary contact if parents cannot be reached:

Name & Relationship: _____ Phone: (____) _____

Doctor's Name & Address: _____ Phone: (____) _____

If Camper has had any of the following, please circle

Chicken Pox

Asthma

Heart Condition

Whooping Cough

Dizziness or Fainting

Measles, Red

Diabetes

Kidney Trouble

Anemia

of any kind

Measles, German

Hepatitis

Tuberculosis

Epilepsy

Mumps

Does Camper have tubes in ears? _____ Are ear plugs required for swim? _____

Is Camper prone to ear infections? _____ Does Camper wear contact lenses? _____

State any physical handicaps: _____ Does Camper have attention span difficulties? _____

Does the Camper suffer from hay fever? Are there any particular troublesome months: _____

Is camper taking any medication at home on a routine basis? (example - drugs for asthma, allergies, etc.). If yes, state medications, dosage and times administered.

Has Camper required counselling for emotional problems? _____

State any physical or emotional concerns or other information that may be useful to the Camp Nurse:

State what operations, recent illnesses or injuries the Camper has had and give details:

Is Camper currently fully immunized against the following diseases?

Check if yes:

Diphtheria

Measles

Haemophilus Influenzae (Hib)

Is camper a carrier of Hepatitis B? _____

Pertussis

Mumps

Pneumo Conjugate

Date of Last TB Test (if applicable) _____

Tetanus

Rubella

Meningococcal C-conjugate

TB Test Result _____

Polio

Varicella (Chicken Pox)

Is camper allergic to penicillin and/or other drugs? (Also state severity of reaction): _____

Bee stings (state severity)? _____ Foods (state severity)? _____ Animals (state severity)? _____

Does Camper have any skin sensitivities? _____ Camper's weight _____

If there are treatments or special medications to be given at camp, state when and how often to be administered (These should be sent to Camp).

PART 2: PARENT AUTHORIZATION & CERTIFICATION

To the best of my knowledge, my child is in good health and has not been exposed to any infectious diseases in the past month. If he/she becomes exposed to any infectious disease between now and the start of camp, I understand the Camp must be notified. I hereby give permission to the Camp Director or his authorized representative to contact my child's physician if the need arises and I authorize any licensed physician to provide medical information about my child. I have disclosed all pertinent medical information including information regarding prescription medication.

Parent's Signature: _____ Date: _____

Print Name: _____