Harmony Lake Children's Summer Camp

15 Margetts Road, Chestnut Ridge, NY 10952

Camp Health History Form for Children, Youth and Adults

to be completed by parents, guardians, or primary caretakers of minors, or by adult campers / staff members themselves

AND ***a hard/ printed copy must be received by July 12, 2024***
To: ***Dr. Margaretha Hertle, 1320 Route 217, Ghent, NY 12075***

Name:_____ Sex:_____ Date of birth:_____ Age_____
Last, First Middle on arrival at camp

Parent or Guardian or Spouse:_____ Home Phone:_____
Home Address:_____ Cell Phone: _____
Business Address:_____ Business Phone:_____

Second Parent or Guardian:_____ Home Phone:_____
Home Address:_____ Cell Phone: _____
Business Address:_____ Business Phone:_____

Other Emergency Contact:_____ Home Phone:_____
Home Address:_____ Cell Phone: _____
Business Address:_____ Business Phone:_____

Health History: *(to be completed by parents or guardians, please check / give approximate dates)*

heart defect or disease _Yes _No
seizures or convulsions _Yes _No
asthma _Yes _No
diabetes _Yes _No
bleeding or clotting disorder _Yes _No
hypertension _Yes _No
frequent ear infection _Yes _No
any other diseases _Yes _No

sleeplessness _Yes _No
sleep walking _Yes _No
bedwetting _Yes _No
anxiety _Yes _No
frequent stomach pain or upset _Y _N
recurrent headaches _Yes _No
for females: has she menstruated?___
If not, has she been told about it?__
Is her menstrual history normal?___

Mononucleosis _____
Lyme disease_____
Chicken Pox_____
Measles_____
German Measles_____
Mumps_____
COVID_____

Details of any of the above, use back or attach additional sheets if needed:

Operations_____
_____

Serious injuries_____

_____
Disability, impairment or chronic recurrent illness_____
_____

Any specific activities limited or encouraged by physician's advice:

Dietary restrictions or modifications:_
_____
_____

Allergies & Sensitivities***:***
(specify what reaction is and age when it happened)
bee/wasp or other insect stings_____
_____
hay fever_____
other trees/pollen_____
penicillin_____
any other drugs or products_____
_____
_____
_____

Current Medications/Supplements:
(Send with instructions if to be given at camp)
_____
_____
_____

Name, address and phone of:

Primary Care Provider/Physician:

Other treating physician:

Dentist:

Orthodontist

Name:_____ Sex:_____ Date of birth:_____ Age_____
Last, First Middle on arrival at camp

Important – We are unable to take responsibility for a child unless we have written authorization to take care of them when there are medical needs or in case of emergency.

This page must be completed and handed in for attendance - in hard-copy format!
We have no reliable internet or phone capability in the infirmary at this camp.

Your child will not be able to come to camp until this is completed and available in the infirmary, INCLUDING BOTH SIGNATURES

Permission & Attestation:

This health history is correct so far as I know and accurately reflects the health status of the camper to whom it pertains.

The person herein described has permission to participate in all prescribed camp activities except as noted by me or an examining physician.

Signature of parent or guardian or adult camper/staffer: _____Date:_____

Emergency / Medical Authorization:

I hereby give my permission to the medical personnel selected by the camp director to administer medical treatment to me/or my child as necessary for routine health care and in emergency situations during camp. Treatment may include x-rays, routine tests and administration of prescribed allopathic medications or homeopathic/ alternative remedies.

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for me/ or my child as named above. I understand that the information on this form will be shared on a "need to know" basis with camp staff. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

This form may be photocopied for use out of camp.

Signature of parent or guardian or adult camper/staffer: _____Date:_____

Medical Insurance Information

The camper is covered by family medical /hospital insurance _Yes _No
Please include a copy of both sides of your insurance card.

Insurance Company:_____ Policy #:_____
Subscriber_____ Insurance Company Phone number_____

Name:_____ Sex:_____ Date of birth:_____ Age_____
Last, First Middle on arrival at camp

PHYSICIAN'S STATEMENT

IMMUNIZATION HISTORY please complete or attach vaccination history
(please record the dates of basic/primary immunizations and booster doses or dates of physician verified illness)

Dates administered: 1. 2. 3. 4. 5.

Diphtheria/ Tetanus/ Pertussis DTP, or DTaP, Tdap
or_____
Tetanus/ Diphtheria DT or Td
or_____
Tetanus T

Polio (Sabin/oral or Salk/injectable) TOPV or IPV

Measles
Mumps MMR (2)
Rubella (German Measles)

Hepatitis B
Varicella (Chicken Pox)
Other:

COVID shot(s) – which one, where, date given
_____
_____
_____

Health Examination by Licensed Physician/PCP (within the past six months**): Date Examined**:_____

Ht:_____ Wt:_____ Heart_____
BP_____ P_____ Abdomen_____
ENT_____ Ext._____
Lungs_____ Spine_____

I have examined the above camp applicant. It is my opinion that they are physically and emotionally fit to participate in an active camp program. __Y __N

Additional health information, restrictions, limitations, or conditions requiring ongoing treatment supervision: (use back of form or attach additional sheets if needed)

Licensed Physician/Provider:

_____
Name (printed) Signature Title Date signed
Office Address:_____

Office Phone Number:_____