

# Summer Program Health Form Checklist

## Summer 2008

Dear Summer Camp Parent,

All parts of pages 1-5 must be completed and returned to the Skylands Summer Camp Health Office at least 1 week prior to arrival on campus.

A physical examination must also be completed and returned to the Camp Health Office prior to arrival on campus. School and Sport physicals are expectable assuming they are within expiration (cannot be older than one (1) year as of September 2008).

Page 1 – Personal Information is to be completed by parents or guardian – complete all sections, being sure to copy there insurance cards (if applicable).

Page 2 – Medications: Please fill out the medication section of the form with the current medications that the camper will be taking at camp. All medication requires a physician's note (RX) to be on file. NO medication will be administered with out proper verifications.

Page 3 –Immunization Record: Dates of ALL immunization must be recorded on this section of the form. Vaccines in **bold** print indicate that it is a State of New Jersey requirement for the participant to have up-to-date. If your physical examination form from your personal physician contains the camper's immunization record, than the Immunization Record section of the history can be left blank. The general questions should be answered to the best of the parents/guardians knowledge.

Page 4- Please sign and date the bottom of the page. No camper will be permitted to attend camp without a proper signature and date.

Page 5- Please fill out the top and sign and date the bottom of this form. It is VERY important to have this form finished and filled out prior to the first day of camp.

### **Important Notes**

All prescription and over-the-counter (OTC) medications to be taken by a camp participant must be left and kept at the Skylands Summer Camp Health Office where the Health Director will set up for the dispensing of the medication. All medication must be in the pharmacy bottle or original store container with proper labeling.

It is advised, prior to mailing these forms, that you make a copy to hand carry to the camp on the child's first day. No camper will be allowed to stay without completed health forms.

For any medical questions, please call the Skylands Summer Camp Health Office at (973) 697- 1600 ext 118.

# Camp Skylands

**Camp Skylands**  
 Skylands Ice World, LLC.  
 2765 State Hwy 23  
 PO Box 710  
 Stockholm, NJ 07460  
  
 MAIN (973) 697-1600  
 FAX (973) 208-9411  
 Updated On: March 2008

Health History and Examination Form  
for Children and Youth Attending Camp  
SUMMER 2008

Camper's Name (Last, First, Middle Initial):			
Camper's Gender: Male / Female	Birth Date: (MM/DD/YEAR)	Grade Entering In September 2008:	
Parent/ Guardian		Relationship:	
Mailing Address:			
City:	State:	Zip:	County:
Home Phone:		Other Phone:	
Name Of Emergency Contact (If I cannot be reached):		Relationship:	
Mailing Address:			
City:	State:	Zip:	County:
Phone:		Other Phone:	
In the event of my absence, may this person care (provide emergency and non-emergency transport) for my child: Yes / No			

**Insurance Information:**

Is the participant covered by medical/hospital insurance: Yes / No      Prescription Plan: Yes / No  
 If so, indicate carrier or plan name: \_\_\_\_\_ Group Number: \_\_\_\_\_  
 Carrier's Address: \_\_\_\_\_  
 Name of Insured: \_\_\_\_\_ Relationship to Participant: \_\_\_\_\_

\*Please Provide a copy of any/all health insurance card(s) in the case of an emergency.

**Health History:**

The following must be filled out by the parent / guardian. The intent of this information is to provide camp health care personnel the background to provide appropriate care. Keep a copy of the completed form for your records. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp. Provide completed information so that the can be aware of your and your child's needs.

**PLEASE NOTE:** All campers **MUST** have a physical examination on file with the camp from their personal health care professional (licensed in the State of New Jersey to perform physical examinations.) School physicals are expectable as long as they are within expiration (must last the entire summer and cannot be older than one (1) year).

**Allergies:** List all known

Medications Allergies (list)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Describe reactions and management of the reaction.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Food Allergies (list)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Describe reactions and management of the reaction.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Other Allergies (list)  
*Examples: Insect stings, hay fever, asthma, ect.*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Description reactions and management of the reaction.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Medication Being Taken:**

Please list ALL medications (including over-the-counter (OTC) or non-prescription drugs) that are taken routinely. Bring enough medications to last the entire time at camp. KEEP it in the original packaging/ bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

**Please Note:** ALL medications that are to be taken at camp MUST be accompanied by a Physicians' notification note that is to stay on file in the Camp's Health Office.

Are there any medications that need to be taken at camp? Yes / No

If yes:

Name of Medication 1: \_\_\_\_\_ Dosage: \_\_\_\_\_

Specific times taken each day: \_\_\_\_\_

Reason for taking medication: \_\_\_\_\_

Name of Medication 2: \_\_\_\_\_ Dosage: \_\_\_\_\_

Specific times taken each day: \_\_\_\_\_

Reason for taking medication: \_\_\_\_\_

Name of Medication 3: \_\_\_\_\_ Dosage: \_\_\_\_\_

Specific times taken each day: \_\_\_\_\_

Reason for taking medication: \_\_\_\_\_

Attach additional pages for more medications.

Identify any medications taken during the school year that does/ may be taken during the summer:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Immunization Record:**

Please give the following dates for all immunizations.

**Please Note:** Immunizations that are in bold print are required to be fully up-to-date before the camp season in accordance with the State of New Jersey Board of Health.

Vaccine:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
<b>DTP</b>	_____	_____	_____	_____	_____	_____
<b>TD (tetanus /diphtheria)</b>	_____	_____	_____	_____	_____	_____
<b>Tetanus</b>	_____	_____	_____	_____	_____	_____
<b>Polio</b>	_____	_____	_____	_____	_____	_____
MMR	_____	_____	_____	_____	_____	_____
<b>Or Measles</b>	_____	_____	_____	_____	_____	_____
<b>Or Mumps</b>	_____	_____	_____	_____	_____	_____
<b>Or Rubella</b>	_____	_____	_____	_____	_____	_____
Haemophilus influenza B	_____	_____	_____	_____	_____	_____
Hepatitis B	_____	_____	_____	_____	_____	_____
Varicella (chicken poxs)	_____	_____	_____	_____	_____	_____
BCG	_____	_____	_____	_____	_____	_____
Last TB mantoux test:	_____			Result:	Positive / Negative	

Which of the following has the participant had?

Measles	Y	N
Chicken Pox	Y	N
German Measles (rubella)	Y	N
Mumps	Y	N
Hepatitis	Y	N

**General Questions** (Explain "yes" answers below.)

Has/does the participant:	Yes	No		Yes	No
1. Had any recent injury, illness or infectious disease? .....	<input type="checkbox"/>	<input type="checkbox"/>	17. Ever had problems with joints (e.g., knees, ankles)? .....	<input type="checkbox"/>	<input type="checkbox"/>
2. Have a chronic or recurring illness/condition? ..	<input type="checkbox"/>	<input type="checkbox"/>	18. Have an orthodontic appliance being brought to camp? .....	<input type="checkbox"/>	<input type="checkbox"/>
3. Ever been hospitalized? .....	<input type="checkbox"/>	<input type="checkbox"/>	19. Have any skin problems (e.g., itching, rash, acne)? .....	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever had surgery? .....	<input type="checkbox"/>	<input type="checkbox"/>	20. Have diabetes? .....	<input type="checkbox"/>	<input type="checkbox"/>
5. Have frequent headaches? .....	<input type="checkbox"/>	<input type="checkbox"/>	21. Have asthma? .....	<input type="checkbox"/>	<input type="checkbox"/>
6. Ever had a head injury? .....	<input type="checkbox"/>	<input type="checkbox"/>	22. Had mononucleosis in the past 12 months? ...	<input type="checkbox"/>	<input type="checkbox"/>
7. Ever been knocked unconscious? .....	<input type="checkbox"/>	<input type="checkbox"/>	23. Had problems with diarrhea/constipation? ....	<input type="checkbox"/>	<input type="checkbox"/>
8. Wear glasses, contacts or protective eye wear? .....	<input type="checkbox"/>	<input type="checkbox"/>	24. Have problems with sleepwalking? .....	<input type="checkbox"/>	<input type="checkbox"/>
9. Ever had frequent ear infections? .....	<input type="checkbox"/>	<input type="checkbox"/>	25. If female, have an abnormal menstrual history? .....	<input type="checkbox"/>	<input type="checkbox"/>
10. Ever passed out during or after exercise? .....	<input type="checkbox"/>	<input type="checkbox"/>	26. Have a history of bed-wetting? .....	<input type="checkbox"/>	<input type="checkbox"/>
11. Ever been dizzy during or after exercise? .....	<input type="checkbox"/>	<input type="checkbox"/>	27. Ever had an eating disorder? .....	<input type="checkbox"/>	<input type="checkbox"/>
12. Ever had seizures? .....	<input type="checkbox"/>	<input type="checkbox"/>	28. Ever had emotional difficulties for which professional help was sought? .....	<input type="checkbox"/>	<input type="checkbox"/>
13. Ever had chest pain during or after exercise? ..	<input type="checkbox"/>	<input type="checkbox"/>			
14. Ever had high blood pressure? .....	<input type="checkbox"/>	<input type="checkbox"/>			
15. Ever been diagnosed with a heart murmur? ...	<input type="checkbox"/>	<input type="checkbox"/>			
16. Ever had back problems? .....	<input type="checkbox"/>	<input type="checkbox"/>			

Please explain any "yes" answers, noting the number of the questions.

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Please list any physical / mental limitations that the participant has:

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Personal Physician: \_\_\_\_\_ Physician Type: \_\_\_\_\_

Office Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Personal Dentist/orthodontist: \_\_\_\_\_

Office Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

Address: \_\_\_\_\_

**Parent / Guardian Authorization:**

*This health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted.*

Signed: \_\_\_\_\_ Printed: \_\_\_\_\_

Date: \_\_\_\_\_

Camper's Name (Last, First, Middle): \_\_\_\_\_

Date of Birth (MM/DD/YEAR): \_\_\_\_\_ Grade in September 2008: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

In an emergency, I hereby give permission to the camp to provide, seek, and consent to routine health care, administration of prescribed medications, and emergency treatment for my child, while at Skylands Ice World's Camp Skylands, as may be necessary, including, but not limited to, x-rays, routine tests and treatments, medical examinations, emergency drug therapy, and/or hospitalization. I also give my permission for the camp director to arrange related transportation. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.

I hereby give permission to the Camp Health Director to administer to my minor child named above the prescription and/or non-prescription medications accompanying them to camp. I give permission for the camp's medical staff to administer basic first aid and care as prescribed by the Camp's On-Call Physician. I understand that the Health Director will not administer any medications by injection unless for emergency purposes (epi-pens, insulin, ect).

The person herein named above has permission to engage in all camp activities except as noted in the Health History Form. It is my intention that the Camp Health Director be treated as acting in loco parentis of the person herein named is a minor.

Further, it is my intention that the appropriate representatives of the camp be treated as "personal representatives" for the purpose of disclosing protected health information pursuant to the privacy regulations promulgated to the Health Insurance Portability and Accountability Act of 1996. I hereby agree (pursuant to 45 CFR 164.510(b)) to the disclosure to camp representatives of the protected health information of the person herein described, as necessary: (i) to provided relevant information to the Camp Director and Health Director related to the person's ability to participate in camp activities; and (ii) in the case of minor injury to provide relevant information to the camps director to keep me informed of my child's health status.

In the event that I cannot be reached in a emergency, I hereby give permission to the Camp Health Director and the selected physician to secure and administer treatment, including but not limited to hospitalization, for the person named above. This completed form may be photocopied for trips and out of camp activities.

This health history is correct and complete as far as I know.

Signature of Parent/ Legal Guardian: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

# Parental Permission Slip

The undersigned parent expressly understands and agrees that Skylands Ice World (SIW) shall in no way be responsible, or in any way be liable, for any injury, claim for damages, pain and/or suffering, or any liability whatsoever arising out of camper's use of, or presence at, SIW at any time. Parent acknowledges that all activities offered at SIW, including those incidental in nature, contain inherent elements of risk which the parent fully accepts and agrees to bear the full burden of. It is the intention of the camper and/or parent to forever waive and release SIW from any claims of any kind whatsoever, in law or in equity, on account of any injury or other damages of any kind, including but not limited to loss of personal property while on SIW premises, or while coming to or from SIW. Camper and/or parent hereby also grants to SIW the right to use any photographic or video images taken of player while at SIW for use for SIW for advertising and/or promotional and marketing purposes.

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

**Mail this form immediately to:**  
**Camp Skylands**  
**2765 State Hwy 23**  
**Stockholm. NJ 07460**