

Camper Health Form

315 Whitemarsh Way
P.O. Box 1513
Cherry Hill, NJ 08034
www.barclayfarm.org



Mail or Fax to: **Camp Barclay**
c/o Katie Foley
79 Winding Way Road
Stratford, NJ 08084

Email: CampOffice@barclayfarm.org

Fax: (567) 429-6052

Child's Name: _____, Date of Birth: _____

Address: _____

Parent or Guardians: _____ (#1); _____ (#2)

Home Phone: _____ (#1); _____ (#2)

Work Phone: _____ (#1); _____ (#2)

Cell Phone: _____ (#1); _____ (#2)

In an emergency notify: _____ Relationship to Child: _____

Address: _____

Phones Home#: _____; Work#: _____; Cell #: _____

Do you need us to administer medicine to your child? Yes No If yes, describe dose and regimen:

Does child have physical, medical or emotional problems? Yes No If yes, please describe:

Does your child take medications on a daily basis? Yes No If yes, list them and reasons taken:

Does your child have any known allergic reactions to the following? Bee Sting Peanuts

Chocolate Penicillin Other Foods Other Drugs Seasonal Allergens Other

What is your child's usual reaction? Hives Rash Anaphylaxis Other

Please describe other: _____

The Camp Directors have permission to administer Benadryl if needed for nonspecific rashes or minor allergic reactions? Yes No (Dosage based on child's age or weight.)

The Camp Directors have permission to administer the following for headaches or minor discomforts?

Tylenol Motrin Aleve Advil Tums

My child needs: Liquid Pill Either

HEALTH HISTORY: (Please check – giving appropriate dates.)

- Frequent Colds _____ Kidney Trouble _____
- Chicken Pox _____ Frequent Sore Throats _____
- Measles _____ Tuberculosis _____
- Bronchitis _____ Mumps _____
- Heart Trouble _____ Whooping Cough _____
- Sinusitis _____ Constipation _____
- Abscessed Ears _____ Convulsions _____
- Poliomyelitis _____ Diabetes _____
- Athlete's Foot _____ Stomach Upsets _____
- Serious Ivy, Oak, Sumac Poisoning _____
- Operations or Serious Injuries _____
- Any Allergies _____

Emotional Stability: Much Some Little None _____

Maturity: Much Some Little None _____

Any Personal Problems: Much Some Little None _____

Any Behavior Problems: Explain _____

Any Learning Problems: Explain _____

Recommendations/Restrictions (diet, medicine, swimming, running, etc.) _____

IMMUNIZATIONS: (Write approx. date of immunization.) DPT Series Tetanus _____

Polio Measles (MMR) _____ Haemphilis (Hib) _____

Is child up-to-date with Tetanus vaccine or Tetanus booster shot? Yes No

In case of emergency, I understand every effort will be made to contact parents/guardian of camper. In the event that I cannot be reached, I hereby give permission to the physician selected by the Director to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child, as named above.

Parent Signature: _____ Date: _____

Physician's Name: _____ Physician's Phone: _____

Physician's Signature: _____ Date of Last Physical: _____

Medical exam is preferred but not required by state law. Doctor's signature is only necessary if camper requires medical clearance to participate in camp activities.