Camper Health Form

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

BARCLAY FARM SUMMER DAY CAMP

BFSC

swim. splash. explore.

Mail to:

Camp Barclay
c/o Katie Foley
79 Winding Way Road
Stratford, NJ 08084

Email: campbarclayfarm@gmail.com

Phone: 856-534-6158

Child's Name: _____ Date of Birth: _____

Address: _____

In an emergency, please contact the following people in this order:

CONTACT 1:	CONTACT 2:	CONTACT 3:	CONTACT 4:
Name:	Name:	Name:	Name:
Relationship to child:	Relationship to child:	Relationship to child:	Relationship to child:
Phone #:	Phone #:	Phone #:	Phone #:
Phone #:	Phone #:	Phone #:	Phone #:
Address:	Address:	Address:	Address:

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 Director/ Head Counselor has 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 Director/ Head Counselor has 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
❑ Chicken Pox
❑ Measles
❑ Bronchitis
❑ Heart Trouble
❑ Sinusitis
❑ Abscessed Ears
❑ Poliomyelitis
❑ Athlete's Foot
❑ Kidney Trouble
❑ Frequent Sore Throats
❑ Tuberculosis
❑ Mumps
❑ Whooping Cough
❑ Constipation
❑ Convulsions
❑ Diabetes
❑ 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: Please **ATTACH YOUR UPDATED IMMUNIZATION FORMS.**

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.