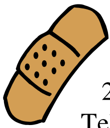

WINNEWALD DAY CAMP HEALTH FORM

Camper's Last Name ______________________________

21 Cratetown Road; Lebanon, NJ 08833
Tel: (908) 735-8336 • Fax: (908) 730-7196

First Name____________________________________ **Birth Date**___________ **Sex** _____ **Age** (at time of camp)________

Parent/Guardian____ **Home Phone** (______) ________________

Home Address____ **Business Phone** (______)_________________

Phone Chain Emergency No. (_____)_____________**Cell /Mom** (____) _______________ **Dad** (_____) ____________

If not available in an **emergency,** please notify:

1.____ (relation) _______________ **Phone** (_____) ______________

2.____ (relation) _______________ **Phone** (_____) ______________

HEALTH HISTORY (Please check where applicable)

Immunizations	**Date/Mo./Year** (for tetanus)	**Allergies***	**Has Had or is Subject To**	
___DPT		___Hay Fever	___Diabetes	___High Blood Pressure
___Polio	___Tetanus________	___Insect Stings	___Rheumatic Fever	___Convulsions/Seizures
___Measles	___Rubella	___Penicillin	___Chicken Pox	___Hypoglycemia
___Mumps	___Hepatitis B	___Other Drugs	___Asthma	___Bleeding Disorders
___Chicken Pox		___Food Allergies	___Heart Trouble	___Attention Deficit Disorder (ADD)
		___Other	___Ear Infections	___AD Hyperactivity Disorder (ADHD)
			___Fainting Spells	___Other ____________________
			___Glasses/Contact Lenses (Sports Goggles required for sports)	

***Allergy description(s)** ____

Activity Restrictions: The Above-Named Camper has the following ***RESTRICTIONS*:** _______________________________

____

Classification: In school, does this camper have an **IEP** or **504**? ❑No ❑Yes (please explain) _____________________

____

Chronic/Recurring Illness or Medical Condition/Operations or **serious injuries** (include dates) ____________________

____

____

Date of most ***RECENT*** Physical Exam_______ **Physician** (signature **NOT** required) ______________________________

Will Camp be asked to administer medication? _______ (If **YES**, you MUST complete our "Medication Authorization Form")

COMMENTS ❒ *check box if continued on the back of this form*____

____

❒ My child and I have discussed the Winnewald Day Camp "*Camper Discipline and Philosophy*" as posted on winnewald.com

***AUTHORIZATION and RECEIPT OF THE WINNEWALD DISCIPLINE POLICY*:**
The Person herein described has permission to engage in all prescribed camp activities **EXCEPT** as those noted by me and the examining physician as stated above. In the event I or my contacts cannot be reached in an EMERGENCY, I hereby give permission to the medical personnel selected by the Camp director or designate to secure proper treatment for, hospitalize, and to order injections, anesthesia, or surgery for my child named above and to release any records necessary for insurance purposes. This completed form may be photocopied for trips off camp premises. I have also received a copy of the camp's discipline policy.

Insurance Information: Insurance carrier or plan name: ___________________________________Group #____________

Name of insured____ Relationship to camper ________________________

Insurance I.D. # ____

____ __________________, 20_____

Signature of Parent or Guardian **Dated** Month, Day **Year**

This Original Form Must Be On File Prior To Camper Attendance

Revised 12/15