



Hammel Tennis Camp  
 524 Boston Post Rd Wayland MA 01778  
 508-358-7355

## CAMPER HEALTH FORM

SECTION ONE - To be filled out by PARENT or GUARDIAN

DATE: \_\_\_\_\_

NAME: \_\_\_\_\_ (FIRST) \_\_\_\_\_ (LAST)

DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_ SEX: \_\_\_\_\_

PARENT/GUARDIAN: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ TOWN: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME TEL.#: \_\_\_\_\_ WORK#: \_\_\_\_\_

CELL PHONE/BEEPER#: \_\_\_\_\_ Does Your Child Need a Floatie to Swim (Yes or No) \_\_\_\_\_

**IN AN EMERGENCY, NOTIFY: (other than parents)**

Can this person pick up your child?  
 (Please circle)

1. \_\_\_\_\_ PHONE#: \_\_\_\_\_ Yes No

2. \_\_\_\_\_ PHONE#: \_\_\_\_\_ Yes No

**People MUST live close by and know they are listed as emergency contact**

CAMPER COVERED BY HEALTH INSURANCE: YES \_\_\_\_\_ NO \_\_\_\_\_

CARRIER: \_\_\_\_\_ POLICY# \_\_\_\_\_

**PLEASE CHECK ALL THAT APPLY WITH DATES (if possible):**

FREQUENT COLDS \_\_\_\_\_ CHICKEN POX \_\_\_\_\_

SORE THROATS \_\_\_\_\_ POLIO \_\_\_\_\_

SINUS/EAR INFECTIONS \_\_\_\_\_ MEASLES \_\_\_\_\_

ASTHMA/BRONCHITIS \_\_\_\_\_ MUMPS \_\_\_\_\_

FAINING \_\_\_\_\_ RUBELLA \_\_\_\_\_

STOMACH PROBLEMS \_\_\_\_\_ WHOOPING COUGH \_\_\_\_\_

RHEUMATIC FEVER \_\_\_\_\_ MENSTRUAL PROBLEMS \_\_\_\_\_

HEART PROBLEMS \_\_\_\_\_ HEADACHES \_\_\_\_\_

DIABETES \_\_\_\_\_ ATHLETES FOOT \_\_\_\_\_

EPILEPSY/SEIZURES \_\_\_\_\_ BOWEL/BLADDER PROBLEMS \_\_\_\_\_

TUBERCULOSIS \_\_\_\_\_ OTHER: \_\_\_\_\_

ANY OTHER HEALTH PROBLEMS/ISSUES/HANDICAPS OR SPECIAL PRECAUTIONS?

\_\_\_\_\_

ANY ACTIVITY OR DIET RESTRICTIONS? \_\_\_\_\_

\_\_\_\_\_

**ALLERGIES:**

MEDICATIONS: \_\_\_\_\_

BEE STINGS: \_\_\_\_\_ FOODS: \_\_\_\_\_

OTHER: \_\_\_\_\_

**MEDICATIONS TAKEN ON A REGULAR OR AS NEEDED BASIS:**

NAME OF MEDICATION: \_\_\_\_\_

DOSAGE: \_\_\_\_\_

FREQUENCY: \_\_\_\_\_ SIDE EFFECTS ETC. \_\_\_\_\_

Will this medication be taken at home or at camp? \_\_\_\_\_

I hereby give my permission for my son/daughter \_\_\_\_\_ to take/have administered the medication(s) noted above. I understand that all medications, prescriptions and/or over the counter, must be in their original containers, must be labeled and have specific directions for use on the label. A prescription medication must include: - the prescription number, medication name, date filled and expiration date, child's name, doctor's name, pharmacy name.

PARENT/GUARDIAN \_\_\_\_\_ DATE: \_\_\_\_\_

**IN CASE OF A MEDICAL EMERGENCY:**

I understand every effort will be made to contact parents/guardians of campers. In the event that I can not be reached, I hereby give my permission for the following: The Physician selected by the Camp Director may secure proper treatment for, hospitalization, order and administer medications and anesthesia, perform x-rays, special procedures, or surgery if deemed medically necessary by him/her for my child.

PARENT/GUARDIAN \_\_\_\_\_ DATE: \_\_\_\_\_

# CAMPER HEALTH FORM

SECTION TWO - To be filled out by your child's Physician

**OR** attach a copy of your child's last well check up form.

CAMPER'S NAME: \_\_\_\_\_

## MANDATORY IMMUNIZATIONS

**\*Child may not attend camp without this information\***

DPT Series (4): \_\_\_\_\_

Td Booster if >10 years since last DPT \_\_\_\_\_

MMR Series: (2) if k-7 (1) if 3-pre K \_\_\_\_\_

Polio Series (at least 3) \_\_\_\_\_

TB skin Test Date(optional): \_\_\_\_\_

HEP B: \_\_\_\_\_

Any Handicaps/Special Precautions/Restrictions or Concerns?

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

Overall State of Health:

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

Allergies to foods, bees, medications or other?

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

Print Physicians Name: \_\_\_\_\_

Signature: \_\_\_\_\_

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

DATE: \_\_\_\_\_

Telephone #: \_\_\_\_\_ License#: \_\_\_\_\_