

John Jay History Camp Medical Form (Please fill out completely)

Name: _____ Birth date _____ Age: _____
Last First Initial

Parent or Guardian name: _____ Phone #: _____

Health History (check-- giving approximate dates where indicated)			
<u>Conditions:</u>	<u>Allergies:</u>	<u>Diseases:</u>	<u>Date:</u>
<input type="checkbox"/> Frequent ear infections	<input type="checkbox"/> Asthma	Mononucleosis	_____
<input type="checkbox"/> Heart disease/defect	<input type="checkbox"/> Hay fever	Chicken Pox	_____
<input type="checkbox"/> Convulsions	<input type="checkbox"/> Poison Ivy	Measles	_____
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Insect sting	German Measles	_____
<input type="checkbox"/> Bleeding/clotting disorder	<input type="checkbox"/> Penicillin	Mumps	_____
Medication taken on a regular basis: _____			
Food allergies: _____			
Special Behavioral needs: _____			
Operations or serious injury (dates): _____			
Other information: _____			

Dietary Restrictions: _____

Current Medication (camp staff can not administer any medication): _____

Other diseases or details not included above: _____

Name of Physician: _____ Phone: _____

Do you carry family medical/hospital insurance? _____

Carrier: _____ Policy or group #: _____

IMPORTANT -- This box must be complete for attendance

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

Signature of parent or guardian _____ Date: _____

Immunization Record

The following immunizations are required for attendance at The John Jay Homestead History Camp. Please record the date (month/year) of basic immunizations and most recent boosters.

This **must** be signed by your physician.

Note: A form from your physician's office will also be accepted.

Vaccines	Date of Basic Immunization	Date of Last Booster
Diphtheria		
Tetanus		
Measles		
Poliomyelitis		
Mumps		
Rubella		
Hepatitis B		
Haemophilus influenza B		
Varicella- chicken pox (not needed if child has had disease)		

Physician's Signature: _____

Date: _____