FUNCAMPS 2012

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HEALTH AND EMERGENCY CONTACT FOR CAMPERS

This form must be completed for EACH CHILD and submitted before June 1st, 2012.It DOES NOT need to be completed by a physician. Important: If camper is 6 years of age or under, Dade County Department of Health requires us to have a PHYSICIAN SIGNED copy of current (within one year of 5/29/12) Certificate of Good Health (HRS Form 3040), Fla. Cert. Of Immunization, Inc. a TB test (HRS Form 680).

Camper's Name_____Age_____ M/F _____

Please check Camp Location **____ University Of Miami** **____Pinecrest Center**
____Jungle Island **_____Saint Philips**

EMERGENCY CONTACTS:

Mother, Guardian, Co parent
Name_____
Home Phone_____
Business phone_____
Other Phone_____

Father, Guardian, Coparent
Name_____
Home Phone_____
Business phone_____
Other Phone_____

Other Contacts
Name_____
Relationship to camper_____
Home Phone_____

City_____
Business Phone _____
Other Phone_____

Physician's Name_____
Dentist's name_____

Physician's phone_____
Dentist's _____

Date of last physical exam_____Do you carry family medical/hospital insurance? Yes____ No ____ If so, indicate carrier_____ Policy/Group_____

Acetaminophen (non asprin compound) can be given for a temperature above 100 degrees, earache, headache, or menstrual cramps. Yes____No____

Benadryl can be given for insect bites/rashes/itching. Yes___ No____

HEALTH HISTORY Check and give approximate dates when applicable.

_____Measles _____Heart Defect/Disease _____Convulsions
_____Frequent Ear Infections _____Bleeding/Clotting Disorders _____Hypertension
_____Chicken Pox _____Diabetes _____Asthma (or inhaler?_____)

ALLERGIES Check all that apply

_____Penicillin _____Insect Stings _____Poison Ivy _____Hay Fever _____
_____Food Allergies Please list all foods_____
_____Other (please describe)_____

IMMUNIZATION RECORD Provide approximate dates

_____ DPT (Diphtheria, Pertussis, Tetanus) _____DT (Tetanus Diphtheria) _____or Tetanus
_____Rubella (German or three day measles) _____Oral Polio (Sabin)TOPV _____Injectable Polio (Salk)
_____Tuberculin test given (date) _____Hepatitis B _____Mumps
_____ Measles (Hard measels, red measles, Rubella) _____ Other (please describe)_____

MEDICAL INFORMATION

Operations or serious injuries_____
Chronic or recurring illness or medical condition_____
Dietary restrictions_____
Current medications_____
Medications taken during the school year_____

RELEASE: This statement must be signed for attendance. This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed activities as noted. **AUTHORIZATION FOR TREATMENT**: I hereby give my permission to the medical personnel selected by the camp director to order X-rays, treatments, and release of any records necessary for insurance purposes and to provide or arrange any transportation for my child (camper) in the event I cannot be reached in emergency. I herby give my permission to the physician selected by the camp director to secure and administer treatment including hospitalization for the above-named person.

_____
sign here date