

**Greenwood Hills 2023**

7062 Lincoln Way East Fayetteville PA 17222  
Phone: 717-352-2150 Fax: 717-352-4844  
www.GreenwoodHills.net

**Note:** This form must accompany camper on registering at camp. **Do not mail in early.** If camper has been exposed to any communicable disease within three weeks immediately before coming to camp, please report this to the nurse upon arrival at camp.

**Health Form and Medical Release Form**

To be filled in by parent/guardian of minors or by adults themselves.

Camper's Name \_\_\_\_\_ Age \_\_\_\_\_ Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_

Parent/Guardian \_\_\_\_\_

Home Address \_\_\_\_\_

Emergency Contact (if parent/guardian cannot be reached), notify:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Phone Number \_ (\_\_\_\_) \_\_\_\_\_

**Parents Emergency Phone Numbers**

Home \_\_\_\_\_

Work \_\_\_\_\_

Cell \_\_\_\_\_

- Check – giving appropriate dates
- \_\_\_\_ Lice/Nits
- \_\_\_\_ ADD/ADHD
- \_\_\_\_ Athlete's Foot
- \_\_\_\_ Bed Wetting-if current
- \_\_\_\_ Chickenpox
- \_\_\_\_ Clotting/Bleeding Disorder
- \_\_\_\_ Constipation/Diarrhea
- \_\_\_\_ Convulsions/Seizures
- \_\_\_\_ Diabetes
- \_\_\_\_ Drug Use
- \_\_\_\_ Ear Concerns
- \_\_\_\_ Eating disorders
- \_\_\_\_ Eczema
- \_\_\_\_ Fainting Spells
- \_\_\_\_ Frequent Colds
- \_\_\_\_ Heart Defect/Disease
- \_\_\_\_ Hepatitis
- \_\_\_\_ Hypertension
- \_\_\_\_ Kidney Trouble
- \_\_\_\_ Lactose intolerance
- \_\_\_\_ Measles
- \_\_\_\_ Mononucleosis
- \_\_\_\_ OCD
- \_\_\_\_ Phobias
- \_\_\_\_ Respiratory/Asthma Issues
- \_\_\_\_ Rheumatic Fever
- \_\_\_\_ Stomach Upsets
- \_\_\_\_ Tuberculosis
- \_\_\_\_ Other \_\_\_\_\_?

**ALLERGIES:**

List all known allergies; describe the reaction and how the reaction is managed.

Medication allergies:

\_\_\_\_\_

\_\_\_\_\_

Food Allergies:

\_\_\_\_\_

Other allergies (include insect stings, hay fever, asthma, animal dander, etc.):

Has camper ever been stung by a bee or wasp? \_\_\_\_\_ Yes \_\_\_\_\_ No

**Medications** List all medications, vitamins and herbals which are brought to camp. Continue on separate sheet if necessary.

*Note: All medication, vitamins, and over the counter medications must be in original labeled containers with your camper's name on it.*

Medication	Dosage and Times taken each day	Reason for Taking

List any hospitalizations and surgeries (include dates and reason for admission): \_\_\_\_\_

List any condition for which camper is currently under a physician's care: \_\_\_\_\_

Has there been a need for professional counseling? Explain. \_\_\_\_\_

Any behavioral/emotional disorders? (Director must give prior approval before camp) Explain \_\_\_\_\_

If a girl, has menstruation begun? \_\_\_\_\_ If not, has she been informed? \_\_\_\_\_

Has camper been out of the USA during the past year? Where? \_\_\_\_\_

**Dentist/Orthodontist** \_\_\_\_\_ Phone Number \_ (\_\_\_\_) \_\_\_\_\_

**Physician's Name** \_\_\_\_\_ Phone Number \_ (\_\_\_\_) \_\_\_\_\_

Do you carry family medical/hospital insurance? \_\_\_\_\_ Yes \_\_\_\_\_ No

Insurance Company \_\_\_\_\_ Policy and/or Group # \_\_\_\_\_

Insurance Company Address \_\_\_\_\_

This health history is correct and complete so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted. **Authorization of Treatment:** In the event of an accident, injury, or sickness, I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, administer treatment and if necessary, hospitalization for the above-named person. I give my permission for the release of any records necessary for insurance purposes. I understand that every effort will be made to contact me; but in the event I cannot be reached, I hereby give permission to the camp director (or a responsible staff member the director appoints) to act on my behalf. I grant permission for camp medical personnel to obtain access to necessary medical, psychiatric, or social work records and to receive the results of medical procedures completed while my child is enrolled at camp.

Signature of Parent/Guardian or adult camper or staff member \_\_\_\_\_ Date \_\_\_\_\_

Camper Name \_\_\_\_\_

**Immunization History**

Please record the date (month and year) of basic immunizations and most recent booster doses.  
(Or attach a photo copy of current immunization record for camper.)

Vaccine:	Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP		_____	_____	_____	_____	_____	_____
TD (tetanus/diphtheria)		_____	_____	_____	_____	_____	_____
Tetanus		_____	_____	_____	_____	_____	_____
Polio		_____	_____	_____	_____	_____	_____
MMR		_____	_____				
Or Measles		_____	_____				
Or Mumps		_____	_____				
Or Rubella		_____	_____				
Haemophilus influenza B		_____	_____	_____	_____		
Hepatitis B		_____	_____	_____			
Varicella (chicken pox)		_____	_____				

**THE FOLLOWING IS TO BE FILLED OUT BY PHYSICIAN ONLY  
IF APPLICANT IS CURRENTLY UNDER DOCTOR'S CARE OR HAS BEEN RECENTLY ILL**

**Health Care Recommendations by Licensed Physician:**

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_

The applicant is under the care of a physician for the following condition(s)

\_\_\_\_\_

Current treatment (include current medications) \_\_\_\_\_

Explanation of any reported loss of consciousness, convulsion, or concussion \_\_\_\_\_

Does applicant have epilepsy?      Yes      No      Does applicant have diabetes?      Yes      No

**Recommendations and Restrictions While at Camp:**

Any treatment to be continued at camp \_\_\_\_\_

Any medication to be administered at camp (specific dosages)

\_\_\_\_\_

Any medically prescribed meal plan or dietary restrictions \_\_\_\_\_

Any allergies (food, drugs, plants, insects, etc...) \_\_\_\_\_

Activities to be encouraged or limited \_\_\_\_\_

Additional Health Information \_\_\_\_\_

I have examined the applicant and have considered that his/her condition does, does not preclude his/her participation in an active camp program, as defined in my examination above.      Date Examined \_\_\_\_\_

Physician's signature \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Number & Street

City

Zip code

Area Code & Number