

# New England Keswick

P.O. Box 156 Monterey, MA 01245 Phone 413-528-3604 fax 413-528-8023

## SUMMER 2006 HEALTH HISTORY AND EXAMINATION FORM

### Personal Information:

Name of Staff Member _____
D/O/B _____ Age _____ Male _____ Female _____ Name(s) of Parent(s) _____
Home Address _____
Home Phone(_____) _____ - _____ Daytime Phone, if different (_____) _____ - _____
Emergency Contact if Person(s) Above Not Available (provide name, address, and phone) _____

### Check (or) give approximate dates if applicable:

Frequent Ear Infections _____ Heart Defect/Disease _____ Convulsions _____ Diabetes _____
Asthma _____ Bleeding/Clotting Disorders _____ Hypertension _____ Mononucleosis _____
Chicken Pox _____ Measles _____ German Measles _____ Mumps _____ Hay Fever _____
Ivy Poisoning, etc. ____ (Specify _____) Insect Stings ____ (Specify _____)
Penicillin Allergy _____ Other Drug Allergies _____ (Specify _____)
Operations or serious injuries (include dates) _____
Chronic or recurring illness or medical condition _____
Dietary restrictions _____
Current medications (send with instructions) _____
Other diseases _____
Name of Dentist/Orthodontist: _____ Phone (_____) _____ - _____
Name of Family Physician: _____ Phone (_____) _____ - _____
Health Insurance Company Name _____ Policy/Group # _____
SPECIAL NOTES: _____

## AUTHORIZATION FOR TREATMENT

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted. **AUTHORIZATION FOR TREATMENT:** I hereby give permission to the medical personnel selected by the New England Keswick to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me/or my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. I have communicated to the person herein described any and all limitations and restrictions on his/her camp activities. The completed forms may be photocopied for trips out of camp.

**Signatures:** Both parents must sign, unless separated or divorced, in which case the custodial parent must sign.  
Legal guardian must sign if applicable.

Father _____	Mother _____
Print Name _____	Print Name _____
Legal Guardian _____	You _____
Print Name _____	Print Name _____

**IMMUNIZATION HISTORY**

Vaccine	Dates				
<b>DTP</b>	1)	2)	3)	4)	5)
<b>DT</b>	1)	2)	3)	4)	5)
<b>Td</b>	1)	2)	3)	4)	5)
<b>One Tetanus or TD Booster required for grades 10-12: Date _____</b>					
<b>Polio</b>	1)	2)	3)	4)	_____
<b>(type: _____)</b>					
<b>MMR</b>	1)	2)	_____		
<b>All Campers 12 and older need MMR Booster: Date _____</b>					
<b>Hib</b>	1)	2)	3)	4)	_____
<b>Hep B</b>	1)	2)	3)	_____	
<b>Tuberculin Test Given on _____ (most recent) Result: _____</b>					

**To Be Completed By Physician:**

<p><b>I examined the person described on this form on the following date:</b> _____                      (per Massachusetts law, examination must be within 12 months of attendance at camp)  <b>In my opinion, his/her condition does /does not preclude participation in an active camp program.</b>                      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</p> <p><b>Recommendations and Restrictions While at Camp</b>                      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 discouraged or limited _____                      Additional instructions or directions _____</p>
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<p><b>Licensed Physician's Signature</b> _____                      Name _____                      Address _____ Phone (_____) _____ - _____</p>
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Date form completed \_\_\_\_\_ By: \_\_\_\_\_