To be completed by a Parent/Guardian

2020Camper Health History Online Forms #1 - #4

BUCKLEY day camp
2 I.U. Willets Road
Roslyn, NY. 11576
516 365-7760
Fax 516 869-0964
www.buckleycamp.com

We are trying to gather as much information about your child as possible so we can prepare in advance for a successful summer. Please keep in mind that only relevant information will be shared with your child's group staff. All information will be held in strict confidence. Please return this form to the camp office by June 1, 2020.

Camper's Name_____ GradeEntering (Sept 2020) _____ Sex: □ M□ F

EMERGENCY INFORMATION

Parent/Guardian Name:_____ Home #:_____Cell/Work:_____
Parent/Guardian Name:_____ Home #:_____Cell/Work:_____

Physician's Name: _____Phone #: _____

DIET

Please check one:□Camper eats a regular and varied diet.□Camper eats a limited diet (please be specific):_____
Is camper gluten-intolerant? □Yes□ NoIs camper lactose-intolerant?□Yes□ No
If yes, please check one:□Camper uses a product like Lactaid and/or can self-manage the intolerance.
□Camper requires a lactose-free diet.
Other dietary restrictions: _____

ALLERGIES

Does your child have allergies (even mild): □ Yes□ No If you answered Yes, please fill out the section below.
Allergy: _____ Type: □ Airborne□ Touch □ Ingestion□ Other: _____
Describe reaction: _____
Your typical procedure: □ Benadryl□ Epi-Pen □ Both □Other:_____Explain: _____

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GENERAL HISTORY

Please check Yes or No for each question.

Ever been hospitalized?	□ Yes□ No	Ever had surgery?	□ Yes□ No
Have recurrent/chronic illness?	□ Yes□ No	Had a recent infectious disease?	□ Yes□ No
Had a recent injury?	□ Yes□ No	Had/has asthma/wheezing/shortness of breath?	□ Yes□ No
Have diabetes?	□ Yes□ No	Had seizures?	□ Yes□ No
Have headaches?	□ Yes□ No	Wear glasses, contact, etc?	□ Yes□ No
Had fainting or dizziness?	□ Yes□ No	Passed out/had chest pains during exercise?	□ Yes□ No
Had mononucleosis in past 12 months?	□ Yes□ No	If female, had problems w/periods?	□ Yes□ No
Have history bedwetting?	□ Yes□ No	Ever had back/joint problems?	□ Yes□ No
Have skin problems?	□ Yes□ No	Have problems w/diarrhea/constipation?	□ Yes□ No
Hearing issues?	□ Yes□ No	Traveled outside US in past 9 months?	□ Yes□ No
Had Chicken Pox ?	□ Yes□ No	Have illness, injury that would affect participation?	□ Yes□ No

If Yes, please explain.

Camper's Name_____

MEDICATION

Does your child currently take any daily medication?□ Yes□ No If Yes, please list medications below

_____

Will your child be taking any daily medication at camp?□ Yes□ No

If yes, please fill out the MEDICATION AUTHORIZATION FORM <Parent and Doctor must fill out this form to administer medication at camp>

MENTAL AND EMOTIONAL HISTORY

Has the camper ever been treated for emotional or behavioral difficulties, OCD, anxiety or eating disorder□ Yes□ No

Has a significant life event that continues to affect the camper's life?…… □ Yes□ No

Has the camper been diagnosed with Attention Deficit Disorder (ADD or ADHD) or other behavioral issues? ..... □ Yes□ No

Has the camper seen a professional to address mental and/oremotional health concerns?.....□ Yes□ No

If Yes, Please explain:

INSURANCE INFORMATION

Is your camper covered by family medical/hospital insurance? □ Yes□ No

Insurance Company/Name of carrier: _____ Policy #: _____

Insurance phone #: _____ Policy holders name: _____

ADDITIONAL INFORMATION

Did we miss anything? Please provide any other information that would be useful to us in caring for your child.

_____

_____

_____

_____

_____

_____

_____

_____

The health information provided on this document is correct and complete to my knowledge. My child has permission to participate in all camp activities except as otherwise noted in writing.

✱ Parent's Signature: _____ Name: _____Date: _____