

# SUMMER DAY CAMP 2009 REGISTRATION FORM



For Office Use Only:

Payment Received  
Cash?   
Check # \_\_\_\_\_  
Card Type: VISA or MC  
Credit Card Number: \_\_\_\_\_

Exp. Date: \_\_\_\_\_  
Name on Card: \_\_\_\_\_

Waiver Received  
 Immunization Form Rcvd.  
 Confirmation Sent

PLEASE CHECK WEEK OR WEEKS REQUESTED (LIMIT 2 WEEKS)

- |  |                                      |
|--|--------------------------------------|
| <input type="checkbox"/> July 6-10       | <input type="checkbox"/> Aug 3 - 7   |
| <input type="checkbox"/> July 13-17      | <input type="checkbox"/> Aug 10 - 14 |
| <input type="checkbox"/> July 20-24      | <input type="checkbox"/> Aug 17-21   |
| <input type="checkbox"/> July 27- Jul 31 | <input type="checkbox"/> Aug 24-28   |

**Learning Center at  
Overlook Farm**  
216 Wachusett St., Rutland, MA  
(508) 886-2221  
(508) 886-5038 fax  
overlook.farm@heifer.org  
www.heifer.org/overlook

Cost per week: \$200 Please make checks payable to "Heifer International"  
Camp Hours: 9:00—4:00 pm  
Do you require extended care? Yes  No   
Morning  (8:30-9:00 am) - \$25 per session or Afternoon  (4-5:30 pm) - \$25 per session or Both —\$50 per session  
Please add the extended care amount to your camp session payment at time of registration.

This form must be filled out completely as required by law. This health form must be completed, signed and returned to Heifer's Overlook Farm at least two weeks prior to the camp session. Parents/Guardians of campers arriving at camp without, or with an incomplete, form will be contacted to pick up their children.

The information contained in this health form is used to advise our day camp coordinator of your camper's current condition and special needs. It also contains the contact information that we will use in the case of an accident or emergency. Information on this form is confidential and will be shared with staff only as appropriate.

## **SECTION A – General Camper Information**

Camper's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address \_\_\_\_\_ Age @ camp: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Gender: M / F

Mother's Name: \_\_\_\_\_ Day Phone: \_\_\_\_\_

(or Guardian) Cell Phone: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Day Phone: \_\_\_\_\_

(or Guardian) Cell Phone: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

### **EMERGENCY CONTACT**

*When parents cannot be reached, who should we contact in case of an emergency?*

Name: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Relationship: \_\_\_\_\_

### **PICK UP AUTHORIZATION**

Please list two additional people (besides mother, father or guardian listed above) who are authorized to pick up your child at camp. We will require picture identification and we will only release your child to the people named on this sheet.

1. \_\_\_\_\_ Phone \_\_\_\_\_

2. \_\_\_\_\_ Phone \_\_\_\_\_

## **Section B – Health History**

### **Allergies**

<i>Mark all known</i>	Specifics	Reaction	Treatment
<input type="checkbox"/> Plants/Pollen			
<input type="checkbox"/> Insect Stings			
<input type="checkbox"/> Food			
<input type="checkbox"/> Medications			
<input type="checkbox"/> Animals			
<input type="checkbox"/> Other			

### **General Questions (Explain “yes” answers below)**

Has/does the participant:

	Yes	No		Yes	No
Had any recent injury, illness or infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>	Ever been diagnosed with a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>
Have chronic or recurring illness/conditions?	<input type="checkbox"/>	<input type="checkbox"/>	Ever had back problems?	<input type="checkbox"/>	<input type="checkbox"/>
Ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	Ever had problems with joints (e.g., knees, ankles)?	<input type="checkbox"/>	<input type="checkbox"/>
Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	Bring an orthodontic appliance to camp?	<input type="checkbox"/>	<input type="checkbox"/>
Have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>	Have a skin problem (itching, rash, acne)?	<input type="checkbox"/>	<input type="checkbox"/>
Ever had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>	Have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
Ever been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	Have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
Wear glasses, contacts or protective eyewear?	<input type="checkbox"/>	<input type="checkbox"/>	Had mononucleosis in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
Ever had frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>	Had problems with diarrhea/constipation?	<input type="checkbox"/>	<input type="checkbox"/>
Ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Had problems with sleepwalking?	<input type="checkbox"/>	<input type="checkbox"/>
Ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Had an abnormal menstrual history?	<input type="checkbox"/>	<input type="checkbox"/>
Ever had seizures?	<input type="checkbox"/>	<input type="checkbox"/>	Had a history of bed-wetting?	<input type="checkbox"/>	<input type="checkbox"/>
Ever had chest pain during or after exercise:	<input type="checkbox"/>	<input type="checkbox"/>	Ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
Ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	Ever had emotional difficulties for which professional help was sought?	<input type="checkbox"/>	<input type="checkbox"/>

Please explain any “yes” answers, noting the number of the questions:

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## ***Section B – Health History continued***

### ***Immunization History***

#### ***Please attach a physician signed certificate of immunizations.***

Required Immunizations (per the Massachusetts Department of Public Health)

1. **Measles, Mumps and Rubella (MMR) Vaccine:** At least one dose of MMR Vaccine must be administered at or after 12 months of age or there must be proof of laboratory evidence of immunity.
  - A second dose of live measles containing vaccine is required for all campers of any age.
  - Both doses of measles vaccine must be given at least one month apart, and be given at or after 12 months of age, or laboratory evidence of immunity.
2. **Polio Vaccine:** At least three doses of either trivalent oral polio vaccine (OPV) or enhanced potency inactivated polio vaccine (e-IPV) are required. If a mixed schedule of polio vaccine is given (IPV and OPV), a total of 4 doses are required.
3. **Diphtheria and Tetanus Toxoids and Pertussis Vaccine:** At least four doses of DtaP/DTP/DT/Td are required. (the pertussis component is not given to anyone seven years of age or older). A booster dose of tetanus/diphtheria, adult type toxoid (Td) is required if more than ten years have elapsed since last dose.
4. **Hepatitis B:** For all children born on or after January 1, 1992, three doses of Hepatitis B vaccine are required.

### ***Additional Health Information***

Are there any specific activities to be restricted, limited, or adapted?

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Specify any dietary restrictions or needs:

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Please tell us any additional information about your camper's behavior and physical, emotional, or mental health which will be useful to our camp health care and/or camp staff:

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If your camper has any needs that will require special accommodation while at camp, please call the Day Camp Coordinator at 508-886-2221. Thank you.

## **Section C – Consent and Permission to Treat**

This health history is correct and complete so far as I know. I hereby give my permission to the **designated health care personnel - including an off site health care consultant and on site health care supervisor** - selected by the camp to provide routine health care, administer prescribed and over-the-counter medications as noted, and to seek emergency medical treatment for my child/ward.

In the event that 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 herein described. I authorize the medications I have listed to be administered by the Health Care Supervisor, as directed to the minor camper for whom it was prescribed.

Signature of Parent/Guardian: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_

### **Medical Information**

Name of Family Physician: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Name of Dentist/Orthodontist: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Medical/hospital insurance \_\_\_\_\_

Policy or Group # \_\_\_\_\_

Name of insured: \_\_\_\_\_ Relationship to camper: \_\_\_\_\_

### **MEDICAL AUTHORIZATION to administer medication at camp**

If your camper needs to have prescribed medication administered during camp hours, this section must be signed by the prescribing physician.

List any medication your camper is bringing to camp, its use and dosage.

All medication must be brought in its original container with the completed pharmacy label and must have specific instructions for use (camper's name, dosage, #of pills, prescribing practitioner, pharmacy name & address). Please add additional sheet of paper if needed.

Medication #1 \_\_\_\_\_ Dose: \_\_\_\_\_ Time to administer: \_\_\_\_\_

Reason for taking: \_\_\_\_\_ Side effects: \_\_\_\_\_

Medication #2 \_\_\_\_\_ Dose: \_\_\_\_\_ Time to administer: \_\_\_\_\_

Reason for taking: \_\_\_\_\_ Side effects: \_\_\_\_\_

Please attach a separate page if more than two medications are prescribed.

Prescribing Doctor: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please identify any medications taken during the school year that camper does/may not take during the summer:

\_\_\_\_\_

**Please Note: Heifer Learning Center at Overlook Farm has a health center (infirmary) that will be stocked with basic first aid supplies. Overlook Farm staff will not administer ANY form of over-the-counter or prescribed medication without receiving the completed form above.**