



Sports, arts, and fun since 1961
Boys and Girls 5-12 · Co-Ed Teen Camp 13-16+

Camp Redwood

Year Round Address:
576 Rock Cut Road
Walden, N.Y. 12586
Phone: (845)564-1180
Fax:....(845)564-1128

Information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care.
(This side to be filled in by parents/guardian of minors or by adult campers/staff members themselves.)

Name _____ Birthdate _____ Sex _____ Age _____
Last First Initial

Parent or Guardian (or Spouse) _____

Home Address _____ Phone _____
Street & Number City State Zip Area/Number

Business _____ Phone _____
Street & Number City State Zip Area/Number

Second Parent or Guardian or Emergency Contact _____

Home Address _____ Phone _____
Street & Number City State Zip Area/Number

Business Address _____ Phone _____
Street & Number City State Zip Area/Number

If not available in an emergency, notify

Name _____

Address _____ Phone _____
Street & Number City State Zip Area/Number

Health History

(Check. Give approximate dates.)

- _____ Frequent Ear Infections
- _____ Heart Defect/Disease
- _____ Convulsions
- _____ Diabetes
- _____ Bleeding/Clotting Disorders
- _____ Hypertension
- _____ Mononucleosis

Diseases

- _____ Chicken Pox
- _____ Measles
- _____ German Measles
- _____ Mumps

Allergies (Dates not needed)

- _____ Hay Fever
- _____ Ivy Poisoning, etc.
- _____ Insect Stings
- _____ Penicillin
- _____ Other Drugs
- _____ Asthma
- _____ Other (Specify) _____

Operations or serious injuries (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 _____

Do you carry family medical/hospital insurance? Yes No

If so, indicate: Carrier _____ Policy or Group # _____

Carrier Address _____

Suggestions on health related information for camp personnel _____

For Female

Has this person menstruated? _____ If not, has she been told about it? _____

If so, is her menstrual history normal? _____ Special Consideration _____

Important — This Box Must be Completed for Attendance*

This health history is correct so far as I know, and the person herein described has permission to engage in all camp activities except as noted.
Authorization for Treatment: I hereby give permission to the medical personnel selected by the camp director 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 director to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

Signature of parent or guardian or adult camper/staffer _____

Witness _____ Date _____

I also understand and agree to abide with the restrictions placed on my camp activities.

Signature of minor or adult camper/staffer _____ Date _____

**If for religious reasons you cannot sign this, then the camp should be contacted for a legal waiver which must be signed for attendance.*

Date Examined _____

Cabin or Tent _____

Year _____

Immunization History

Required immunizations must be determined locally. Please record the date (month and year) of basic immunizations and most recent booster doses.

Vaccines	Year of Basic Immunization	Year of Last Booster
Diphtheria Pertussis (Whooping Cough) Tetanus or	1 2 3	1 2
Tetanus Diphtheria or		
Tetanus		
Oral Polio (Sabin)* TOPV		
Injectable Polio (Salk)		
Measles (hard measles, red measles, rubeola)		
Mumps		
Rubella (German measles, 3-day measles)		
Other		
Tuberculin test given _____ (most recent)		
Haemophilus influenza b (HIB)		
Hepatitis B		

Health Care Recommendations by Licensed Physician

I have examined the above camp applicant. Date Examined _____

In my opinion, the above's condition does does not preclude his/her participation in an active camp program.

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 _____

Licensed Physician's Signature _____	
Address _____	Phone _____
<small>Street & Number City State Zip Code</small>	<small>Area/Number</small>
Date of Form Completion _____	*By _____
<small>*Initial if completed by nurse or physician's assistant.</small>	