MUST COMPLETE BOTH SIDES OF FORM.

Camp Sojourner: Girls' Leadership Camp Session: **July 29 – August 3, 2019**

801 S. 48th Street, PA 19143 Phone: 215-951-0330 x2180 **Return this form by: June 1, 2019**

2019 Health History & Examination Form

This form is a requirement for all campers. If the completed form is not returned by June 1, 2019, your child may not be permitted to attend Camp Sojourner.

PAGES 1, 2, AND TOP HALF OF PAGE 3 TO BE COMPLETED BY PARENT/GUARDIAN:

CAMPER INFORMATION:

Child's Last Name: _____Date of Birth: ___/___/_____ Age at Camp: _____

Child's First Name: _____ School Child Attends:_____

Social Security Number of camper**: __ __ __ - __ __ - __ __ __ __**

PARENT INFORMATION:

Parent/ Guardian 1 Name: _____ Email: _____ Home: _____

Employer: _____Work: _____ Cell: _____

Parent/ Guardian 2 Name: _____ Email: _____ Home: _____

Employer: _____ Work: _____Cell: _____

Camper Home Address:_____ Apt #_____

City: _____ State: _____ Zip: _____

Please list two people who could be contacted in case of emergency, in the event we cannot reach parent/guardian:

Emergency Contact 1:_____ Relationship to child: _____

Home Phone: _____ Cell: _____ Work: _____

Emergency Contact 2:_____ Relationship to child: _____

Home Phone: _____ Cell: _____ Work:_____

INSURANCE INFORMATION

Is the camper covered by health insurance? ___Yes ____No

If so, indicate name of insurance plan _____ Group Number_____

Insurance Plan's address_____

Name of Plan Holder_____ Relationship to Camper _____

Insurance ID number or social security number of plan holder_____

**********IMPORTANT: THIS BOX MUST BE COMPLETED FOR ATTENDANCE**********

Permission to Provide Necessary Treatment or Emergency Care: I hereby give my 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 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 health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted.

♥**Signature of Parent or Guardian** _____

Printed Name _____**Date** _____

TO BE COMPLETED BY PARENT/GUARDIAN:

HEALTH HISTORY: The following information must be filled in by the parent/guardian. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp.

Does your child have any health problems? ___Yes ____No Is he/she under the care of a physician? ___Yes ____No
Please Explain _____
_____

Does your child have any food restrictions or allergies? ___Yes ____No

Food restriction or allergy	Severity—Epipen required in case of consumption yes or no?	If **milk or lactose issue**, can child have food with milk cooked in it or small amounts of cheese i.e. on pizza, or no dairy even in cooked or baked items?	If **egg issue**, can child have food with egg cooked in it such as baked goods? Or no eggs whatsoever, even in cooked or baked items?

Does your child take any medications? ___Yes* ____No

Name of Medication	Purpose	Dosage	When to administer

PLEASE NOTE: **All medications you send to camp must be included in physical form or other doctor note, including all over-the-counter medications.*

INFORMATION THAT MAY HELP US TO BETTER SERVE YOUR CHILD AT CAMP:

Assistance Needed: Please check ( ) all that MAY apply							
	Vision		Brushing teeth		Environmental Allergies		Glasses/ contacts
	Understanding instruction		General Hygiene		Religious Restriction		Physical Restriction
	Hearing		Bed wetting		Asthma		Skin problems
	Mobility		Dressing		Headaches		Fears & Severe dislikes

If you checked any of the above, please explain fully any information regarding the assistance your child may need. BE AS SPECIFIC AS POSSIBLE. (For example: must wear ear plugs in pool due to tubes in ears, needs directions broken into steps, etc...)

Use this space to provide any information about special behavioral / developmental concerns such as ADD, ADHD, Autism spectrum disorders, etc. Please explain _____
_____
_____

PERMISSION TO GIVE AS NEEDED MEDICATIONS AT CAMP:

I give permission for the Camp Nurse to administer the following medication to my child if needed.
( ) Tylenol ( ) Benadryl ( ) Pepto Bismol

Signature:_____ Date:_____

PLEASE NOTE: We have a doctor's order to administer the medication listed above, as long as we have parent/guardian permission. However, **any other medication you send, including over-the-counter medications, must be included in your doctor's exam or other doctor's note. We can only administer medications for which we have a doctor's order. We apologize for any inconvenience and are happy to work with you in advance of camp to ensure your child is able to receive all necessary medications.*

CAMPER NAME: _____ D.O.B.: _____

PHYSICIAN CONTACT INFORMATION:

Name of family physician: _____ Phone: _____

Address: _____

Name of family dentist/ orthodontist: _____ Phone: _____

Address: _____

DISEASE/IMMUNIZATION HISTORY:

Please attach immunization record from your doctor to this form.

THE FOLLOWING MUST BE COMPLETED BY LICENSED MEDICAL PERSONNEL:
(Note to parents/guardians: You may attach a signed/stamped exam record from your doctor in lieu of completing section below. Exam must be dated after 7/29/18.)

I have examined the applicant. Date of examination _____

BP _____ Weight _____ Height _____

In my opinion, the above applicant ☐ is ☐ is not able to participate in an active camp program.

Is the applicant "up to date" on his/her immunizations? ___Yes ____No

The applicant is under the care of a physician for the following conditions: _____
_____
_____

Current treatment at the time of this report includes: _____
_____
_____

Recommendations and Restrictions At Camp:
Treatment to be continued at camp _____
_____
_____

Medications to be administered at camp:

Name of Medication	Purpose	Dosage	When to administer

Any restrictions while at camp, either dietary or physical? _____
_____

Signature of Licensed Medical Personnel _____ **Date** _____
Printed _____ Title _____
Address _____ Phone _____

DIETARY RESTRICTION FORM

Name: _____
Age: _____
Camp assignment (staff, camper, TLI, CPS): _____

This form must be completed and **returned by June 15** so that necessary eating arrangements may be made at camp. All participants MUST complete this form regardless of whether or not you have any dietary restrictions.

PLEASE NOTE THE DIETARY POLICY of the New Jersey School of Conservation, our rental site for the week of camp: *In order to avoid the possibility of a food-related medical emergency, children/ guests will only be served items that conform with the dietary restrictions submitted by their parents/ guardians and indicated on the Special Diets Form. If a parent/guardian notes a particular allergy or a specific food to avoid, only items that meet the restrictions will be served to that child/guest. The NJSOC kitchen staff will follow the written instructions and will not change any guests' menus once they are on site.*

_____ Check here if camper/staff member has NO DIETARY RESTRICTIONS

Please check any of the following that apply to camper/staff member:
____ Lactose intolerant—no dairy in anything
____ Lactose intolerant—can eat dairy cooked in things but not milk or ice cream in large quantities.
____ Vegetarian (will eat dairy products, but not meat)
____ Vegan (no animal products whatsoever)
____ Gluten free

Please list any food allergies camper/staff member has. If any allergies are severe enough to require an epipen, please put an *asterisk next to it.

____Nuts (please specify: _____)
____Eggs (can you eat eggs cooked in bread or no eggs whatsoever? _____)
____Other: _____

Please list any other dietary restrictions. (Note: This is not an area to list foods that you dislike! Please only list foods may not be eaten due to religious or health reasons.):

FOR CAMP USE ONLY

Date screened: _____ Time: _____

Meds received: _____

Updates/additions to health history noted? __ Yes __ No __ None required

Current health needs identified? _____

_____

Observational notes: _____

_____

Screened by:_____