

# Camp Creek Run

199 Taunton Lake Rd., Marlton NJ 08053 ♦ (Ph) 856-596-4250 ♦ (Fax) 856-596-4004

## Personal Health and Medical Record

**Does NOT require a doctor's signature • Registration not complete until form is received**

Office Use Only:  
Village Name

Camper/Staff Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Grade NEXT September: \_\_\_\_\_ Gender \_\_\_\_\_

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

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

### In Case of Emergency Notify (contacts will be notified in the order they appear here):

Parent/Guardian 1: \_\_\_\_\_ Custodial Parent?  Yes  No

Home #: ( ) \_\_\_\_\_ Work #: ( ) \_\_\_\_\_ Cell #: ( ) \_\_\_\_\_

Parent/Guardian 2: \_\_\_\_\_ Custodial Parent?  Yes  No

Home #: ( ) \_\_\_\_\_ Work #: ( ) \_\_\_\_\_ Cell #: ( ) \_\_\_\_\_

Other Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home #: ( ) \_\_\_\_\_ Work #: ( ) \_\_\_\_\_ Cell #: ( ) \_\_\_\_\_

Other Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home #: ( ) \_\_\_\_\_ Work #: ( ) \_\_\_\_\_ Cell #: ( ) \_\_\_\_\_

### MEDICAL CONDITIONS / ALLERGIES REQUIRING MEDICATION (attach separate sheet if necessary):

**BEHAVIORAL/DEVELOPMENTAL/NEUROLOGICAL CONCERNS:** Describe any **behavioral, developmental, and/or neurological concerns**, including school classifications & clinical diagnoses. Advise if your child is assigned an aide during the school year, is in a self-contained classroom, or requires special assistance. If in a self-contained classroom, please list teacher/student ratio. Attach a separate sheet as needed. (CCR is unable to provide 1-to-1 assistance or counselor/camper ratios beyond what is typical for summer day camp.)

### Emergency Medical Information

Has or is subject to (please check box and describe):

- Asthma:
- Convulsions:
- Fainting Spells:
- High Blood Pressure:
- Allergy or reaction to any medicine, food, plant, animal, or insect toxin:
- Diabetes:
- Contact Lenses:
- Heart Conditions:

- Any other condition that may require emergency or special care, medication, or knowledge:

Approved for participation in (please specify exceptions):

- Hiking & Camping
- Water Activities
- Competitive Sports
- All Activities

Please explain any physical restrictions or limitations:

Camper/Staff Name \_\_\_\_\_

**Personal Health and Medical Form, Cont'd**

**Immunization History (Please attach records):**

	Month/Year Given	Check if Needed		Had Disease	Had Vaccination	Check if Needed
Tetanus	_____	<input type="checkbox"/>	Measles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diphtheria	_____	<input type="checkbox"/>	Mumps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Polio	_____	<input type="checkbox"/>	Rubella	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b><u>ATTACH IMMUNIZATION RECORDS</u></b>			Whooping Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family Doctor's Name: _____			Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family Doctor's #: _____						

**Is there disease of or present or past history of:**

	No	Yes	Year/Details (if any)		No	Yes	Year/Details (if any)
Serious Illness	<input type="checkbox"/>	<input type="checkbox"/>	_____	Stomach, bowels	<input type="checkbox"/>	<input type="checkbox"/>	_____
Serious Injury	<input type="checkbox"/>	<input type="checkbox"/>	_____	Appendicitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Deformity	<input type="checkbox"/>	<input type="checkbox"/>	_____	Kidneys	<input type="checkbox"/>	<input type="checkbox"/>	_____
Surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____	Urinary Tract Infection	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin, glands	<input type="checkbox"/>	<input type="checkbox"/>	_____	Bed-wetting	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ears, eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Menstrual problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Nose, sinus	<input type="checkbox"/>	<input type="checkbox"/>	_____	Hernia rupture	<input type="checkbox"/>	<input type="checkbox"/>	_____
Teeth	<input type="checkbox"/>	<input type="checkbox"/>	_____	Back, limbs, joints	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tonsils	<input type="checkbox"/>	<input type="checkbox"/>	_____	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart	<input type="checkbox"/>	<input type="checkbox"/>	_____	Behavioral Condition	<input type="checkbox"/>	<input type="checkbox"/>	_____
Murmur	<input type="checkbox"/>	<input type="checkbox"/>	_____	Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

**Parent's Authorization—THIS FORM MUST BE SIGNED BELOW OR REGISTRATION IS INVALID**

I hereby authorize any medical treatment deemed necessary in the event of any injury to my child while participating in any activity. In the event I cannot be reached in an emergency, I hereby give permission to the physician or RN selected by the camp director to secure proper treatment for my child as named above. I have appropriate insurance or, in its absence, I agree to pay all costs of rescue and/or medical services as may be incurred on my behalf of my child.

To the best of my knowledge, history is correct and complete. I know of no reason to restrict applicant's activity, and give my permission for participation in all activities except as specifically noted herein. I recognize that there is inherent risk in any activity which involves physical exertion; that natural hazards exist; that although the program may not be strenuous, injuries or medical complications may occur; that certain foreseeable and unforeseeable events unique to each individual activity can contribute to the unpredictability of the activity; that balance and physical coordination may affect the occurrence of accidents or falls; and that I should ask about other potential hazards and recommended precautions and procedures. In recognition of the inherent risk the activity which my child will be engaged in, I confirm that my child is physically and mentally capable of participation in the activity and/or using equipment. I understand that my child will be participating willingly and voluntarily and I assume full responsibility for personal injury, accidents, or illnesses including, but not limited to: cuts, scrapes, and abrasions; insect bites and related illnesses; sprains, torn ligaments, and broken bones, etc. I also assume responsibility for damage to or loss of personal property as the result of any accident that may occur. On behalf of myself, my child and any other parent of the child, I assume the risks of personal injury, accidents, and or illnesses. In consideration of services or property provided, I, for myself, for my child, and for any other parent of the child, do hereby release Project HEAL, Inc./ Camp Creek Run its principals, trustees, directors, officers, agents, employees, and volunteers from all liability with respect to my child and I waive any claim for damage arising from any cause whatsoever, except for any claims which are the result of gross negligence of the party of parties released herein.

**Parent/Guardian or Staff Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Parent/Guardian or Staff Name (please print):** \_\_\_\_\_

**Office Use Only:** Reviewed by Camp Nurse (Initials) \_\_\_\_\_ **Date:** \_\_\_\_\_

Reviewed by Group Leader (Initials) \_\_\_\_\_ **Date:** \_\_\_\_\_