

THIS MEDICAL RECORD must be returned no later than **June 16, 2007. A Late Fee of \$10.00 will be assessed if received after June 16, 2007.**

No camper/ counselor will be allowed to attend camp without a MEDICAL RECORD on file.

Grade in September _____ Social Security # _____

Name _____ Age _____ Date of Birth _____

Address _____ Home Phone # _____

Responsible Party's Name _____

Mother's Name _____ Work Phone # _____ Beeper/cell # _____

Father's Name _____ Work Phone # _____ Beeper/cell# _____

Emergency Contact Names _____ Phone # _____

(other than parents) _____ Phone # _____

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THIS PORTION TO BE COMPLETED BY PHYSICIAN

Check if camper/ counselor has had the following:

- | | |
|---------------------|-----------------------|
| Chickenpox _____ | Scarlet Fever _____ |
| Diphtheria _____ | Nosebleeds _____ |
| Asthma _____ | Whooping Cough _____ |
| Measles _____ | Rubella _____ |
| Mumps _____ | Ivy Poisoning _____ |
| Epilepsy _____ | Oak Poisoning _____ |
| Poliomyelitis _____ | Rheumatic Fever _____ |

IMMUNIZATIONS REQUIRED

Record Date of Last Injection Required, if known:

- | | |
|----------------------|-----------------|
| Tetatus Toxoid _____ | Measles _____ |
| Polio _____ | Rubella _____ |
| Diphtheria _____ | Hepatitis _____ |
| Other _____ | |

Surgery (please specify) _____

Medication being taken (Daily or PRN) -- Additional "Medication Form" must be completed and attached

Medication _____	Reason _____
_____	_____

- Special Allergies _____
- Reaction to insect bites & bee stings _____
- Any special educational or emotional concerns we should be aware of: _____

- Activities in which individual may not participate: _____

Date _____ **Physician's Signature** _____

Physician's Name _____
(PRINT) Address _____ Phone # _____

In case of sickness or injury and you are unable to be contacted, we will consult with our local camp physician who will be on call and available all summer for emergency treatment and recommendations. If so recommended, Camp White Meadow will take your child to St. Clare's for emergency treatment.

**** Parent's Signature** _____ **Date** _____

(If over 18, individual may sign)