

RETURN TO:  
**CAMP WATTOH**  
28 SAMMIS LANE  
WHITE PLAINS, NY 10605

By \_\_\_\_\_ (Date)

Camper's Name

This side to be filled in by parents/guardian of minors or by adult campers/staff members themselves.

Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_

Parent or Guardian (or Spouse) \_\_\_\_\_ Phone \_\_\_\_\_

Home Address \_\_\_\_\_  
Street & Number City State Zip Code

Business Address \_\_\_\_\_ Phone \_\_\_\_\_  
Street & Number City State Zip Code Area/Number

Second Parent or Guardian or Emergency Contact: \_\_\_\_\_

Home Address \_\_\_\_\_ Phone \_\_\_\_\_  
Street & Number City State Zip Code Area/Number

Business Address \_\_\_\_\_ Phone \_\_\_\_\_  
Street & Number City State Zip Code Area/Number

If not available in an emergency, notify:

Name \_\_\_\_\_ Phone \_\_\_\_\_  
Area/Number

Address \_\_\_\_\_  
Street & Number City State Zip Code

**Health History:** (Check-giving approximate dates)

**Allergies**

Frequent Ear Infections	Mononucleosis	Hav Fever
Heart Defect/Disease	<b>Diseases</b>	Ivy Poisoning, etc.
Convulsions	Chicken Pox	Insect Stings
Diabetes	Measles	Penicillin
Bleeding/Clotting Disorders	German Measles	Other Drugs
Hypertension	Mumps	Asthma

Operations or serious injuries (dates): \_\_\_\_\_

Disability or chronic or recurring illness: \_\_\_\_\_

Any specific activities to be encouraged or limited by physician's advice: \_\_\_\_\_

Dietary modifications: \_\_\_\_\_

Current medication (send with instructions): \_\_\_\_\_

Other diseases or details of above: \_\_\_\_\_

Name of dentist/orthodontist: \_\_\_\_\_ Phone \_\_\_\_\_  
Area/Number

Name of family physician: \_\_\_\_\_ Phone \_\_\_\_\_  
Area/Number

Date of last physical examination: \_\_\_\_\_

**(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 prescribed camp activities except as noted. I understand that there are risks inherent in camp activities and give my consent to my child's participation in such activities. I will instruct my child to refrain from participation in any activity that he/she feels unqualified.

**Emergency Authorization:** I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests and treatment for me/or my child, and in the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for me/or my child as named above. This form may be photocopied for use out of camp.

Signature of parent or guardian or adult camper/staffer \_\_\_\_\_

Date \_\_\_\_\_

Cabin

# CERTIFICATE OF IMMUNIZATION

**Immunization History:** Provide the month and year for each immunization. Starred (\*) immunizations must be current. Copies of immunization forms from health-care providers or state or local governments are acceptable. Please attach to this form.

Immunization	Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most Recent Dose Month/Year
Diphtheria, tetanus, pertussis* (DtaP) or (TdaP)						
Tetanus booster* (dT) or (TdaP)						
Mumps, measles, rubella* (MMR)						
Polio* (IPV)						
Haemophilus influenzae type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox)	Had Chicken Pox Date:					
Meningococcal meningitis (MCV4)						

Tuberculosis (TB) test                      Date: \_\_\_\_\_                      Negative                      Positive

**Health Examination 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.

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.): \_\_\_\_\_

Additional Health Information: \_\_\_\_\_

Licensed Physician's Signature \_\_\_\_\_                      Phone \_\_\_\_\_

Address \_\_\_\_\_

Date of Form Completion \_\_\_\_\_                      \*By \_\_\_\_\_

\*Initial if completed by nurse or physician's assistant.