# HEALTH HISTORY FORM


THIS PAGE MUST BE COMPLETED AND SIGNED BY A PARENT/GUARDIAN. A COPY OF THE CHILD'S MOST RECENT PHYSICAL AND VAX RECORD MUST ACCOMPANY THIS FORM IN ORDER FOR THE CHILD TO BE ELIGIBLE TO PARTICIPATE IN CAMP.

## CAMPER INFO

Name:_____

Birthdate_____ Sex_____ Age_____

Home Address_____

City_____ State_____ Zip_____

Allergies:_____

## PARENT/GUARDIAN INFO

Home Address_____

City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____

Work Phone

**Emergency Contact #1)**_____ Relationship_____ Phone_____

**Emergency Contact #2)**_____ Relationship_____ Phone_____

**Medical History**

Are you, or have you ever been treated for any of the following:

| Yes | No | Condition | Explain |
|---|---|---|---|
| | | Frequent Ear Infections | |
| | | Heart Defect / Disease | |
| | | Seizures | |
| | | Diabetes | |
| | | Bleeding Disorders | |
| | | Chicken Pox | |
| | | Asthma | |
| | | Frequent Bloody Nose | |
| | | Surgery | |
| | | Poison Ivy | |
| | | Insect Stings | |
| | | Broken Bone | |
| | | Sprain | |

Name of child's physician_____ Phone_____

Name of child's dentist/orthodontist_____ Phone_____

**Medical Insurance Information**

| | | | |
|---|---|---|---|
| Subscriber Name | | SSN (optional) | |
| Carrier Name | | Carrier Address | |
| Group Name | | Group Numer | |

This information is correct and complete to the best of my knowledge. My child _____has my permission to participate in all camp activities except as noted by me, and/or the examining physician. I give permission to the camp to provide routine health care, administer pre-perscribed medications, and seek emergency medical treatment including x-rays, and routine tests. In the event that I cannot be reached in an emergency, I hereby give permission to the camp healthcare supervisor to secure and administer treatment, including hospitalization, for the person named above.

**Signature**_____ **Date**_____

# MEDICATION AUTHORIZATION FORM

Completed by a parent/guardian

All campers bringing medications to camp including perscription, over-the-counter, supplements, and topical medications must have a Medication Authorization Form on file. All medications brought to camp must be kept by the camp director. No camper may carry their own medications with their belongings. All prescription and over-the-counter medication, must be received in it's oiriginal container, bearing a label including the child's name. Medications brought to camp must come with the child at the beginning of each camp day, and leave with the child at the end of each day. NEAG will not keep medications on site overnight.

| CAMPER AND PARENT/GUARDIAN INFORMATION | |
|---|---|
| Camper's Name: | |
| Age: | Food/Drug Allergies: |
| Diagnosis (at parent/guardian discretion): | |
| Parent/Guardian Name: | |
| Home Phone: | Cell Phone: |
| Emergency Contact: | Phone: |
| As the parent of the above named camper, I hereby authorize New England Academy of Gymnastics to administer my child the medications as indicated below. If there is a change in perscription, the child's health care provider must provide documentation.<br><br>Parent / Guardian Signature _____ | |

| LICENSED PRESCRIBER INFORMATION | |
|---|---|
| Name of Licensed Prescriber: | |
| Business Phone: | |

| MEDICATION 1 | |
|---|---|
| Name of Medication: | Dosage: |
| Route of Administration: | Frequency: |
| Date Issued: | Expiration Date: |
| Special Storage Requirements: | |
| Special Directions (ie: on empty stomach/with water): | |
| Special Precautions: | |
| Possible Side Effects: | |

| MEDICATION 2 | |
|---|---|
| Name of Medication: | Dosage: |
| Route of Administration: | Frequency: |
| Date Issued: | Expiration Date: |
| Special Storage Requirements: | |
| Special Directions (ie: on empty stomach/with water): | |
| Special Precautions: | |
| Possible Side Effects: | |