



Parent, guardian, or physician may complete this information.

**GENERAL QUESTIONS (Explain "YES" answers below.)**

(ACA accreditation requirements specify exams within 12 months of camp attendance)

BP \_\_\_\_\_ WEIGHT \_\_\_\_\_ HEIGHT \_\_\_\_\_

**T B MANTOUX TEST/DATE OF LAST TEST \_\_\_\_\_**  
**RESULT: \_\_\_ POSITIVE \_\_\_ NEGATIVE**

**PLEASE INDICATE DATE OF IMMUNIZATIONS:**

|                         | <u>Mo./Yr.</u> | <u>Mo./Yr.</u> | <u>Mo./Yr.</u> | <u>Mo./Yr.</u> | <u>Mo./Yr.</u> |
|-------------------------|----------------|----------------|----------------|----------------|----------------|
| DTP                     | _____          | _____          | _____          | _____          | _____          |
| DT                      | _____          | _____          | _____          | _____          | _____          |
| German Measles          | _____          | _____          | _____          | _____          | _____          |
| Mononucleosis           | _____          | _____          | _____          | _____          | _____          |
| Mumps                   | _____          | _____          | _____          | _____          | _____          |
| Rubella                 | _____          | _____          | _____          | _____          | _____          |
| Hamophilus influenza B  | _____          | _____          | _____          | _____          | _____          |
| HEPATITIS B             | _____          | _____          | _____          | _____          | _____          |
| Varicella (Chicken Pox) | _____          | _____          | _____          | _____          | _____          |
| Polio                   | _____          | _____          | _____          | _____          | _____          |

Current treatment/Medications: Any Limitations: \_\_\_\_\_

Allergies: \_\_\_\_\_ None \_\_\_\_\_ Yes (List): \_\_\_\_\_

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

**Recommendations/Restrictions while at camp:**

Does the child have a bronchial inhaler, bee sting kit, epi-pen or other health related device? \_\_\_\_\_

Medication(s) to be administered (Includes dosages and times of administration); \_\_\_\_\_

Any medically prescribed meal plan or dietary restrictions: \_\_\_\_\_

To the best of my knowledge, there \_\_\_\_\_ is \_\_\_\_\_ is not, a medical contraindication to administering acetaminophen (Tylenol).

Camper's Licensed Physician's Name (Please Print): \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date of completion of this form \_\_\_/\_\_\_/\_\_\_

|   |       |
|---|-------|
| <b>I hereby attest that the information on both side of this form is correct.</b> |       |
| _____   | _____ |
| Guardian/Parent/Physician Signature   | Date  |

**Camp Yomawha is licensed by the Rockland County Department of Health, and is inspected annually. Inspection reports are filed in the Camp Office.**