

SummerQuest 2012 Health Form



PLEASE RETURN FORMS TO:

The Crane Estate | Attn: SummerQuest | 290 Argilla Road | Ipswich, Ma 01938

Section I Please complete this section with honesty and care. The more we know, the better equipped we are to keep your child safe and happy. A parent or legal guardian must sign and date this section.

CAMPER INFORMATION				
_____	_____	_____	_____	_____
Last	First	Initial	DOB	Gender
_____		_____	_____	_____
Street	City	State	Zip	

BACKGROUND	
Does your child require special attention due to a medical or behavior condition? Special attention includes but is not limited to things like attention deficit disorder, asthma, phobias and bathroom issues. Yes No	
<i>If you answered yes, please provide as much detail as possible on a separate sheet.</i>	
Does your child suffer from an allergy? Yes No	
If yes, please name the allergy _____	
Has your child been screened for developmental delays? Yes No	
Does your child have an IEP? Yes No <i>If you answered yes, please include a copy.</i>	

DOCTOR INFORMATION
Family Physician _____
Phone _____
Office Address _____
Date of Last Physical _____

INSURANCE PROVIDER
Insurance Carrier _____
Policy Holder Name _____
Policy/Group # _____

MEDICATION
Will your child bring medication (including over the counter medicine) to camp? Yes No
Medication _____ Purpose _____
Please circle the medications you would like us to administer when necessary?
Tylenol Antacid Nasal Decongestant Insect Repellant Ibuprofen Itch Cream Calamine Sunscreen Benadryl Antibiotic Cream

Parent / Guardian Signature

Date

Section II Each camper must provide proof of physical exam within one year of attending camp. Each camper must also provide a certificate of immunization, which includes the month, year and type of immunization or occurrence of clinical disease. We will accept a form generated directly by a physician's office, or the form below. **This form must be signed and dated by a physician or designee.**

PHYSICAL EXAMINATION			
Date of Last Physical Exam ____/____/____		HT:____ WT:____ HC:____ BP:____	
Hearing _____	Vision _____	Any restriction on normal activity? Yes No	
Comments _____			
Special Notice _____			
Has this child ever suffered from:			
Frequent Ear Infection	Yes No	Pneumonia	Yes No
Bronchitis	Yes No	Surgery	Yes No
Kidney Problems	Yes No	Hospitalization	Yes No
Heart Problems	Yes No	Broken Bones	Yes No
Convulsions	Yes No	Chicken Pox	Yes No
If "Yes," please explain _____			
Abnormal Findings?	Yes No	If yes, what? _____	

IMMUNIZATION HISTORY

Vaccine:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP/DTaP/DT						
Td (Tetanus/diphtheria)						
Polio						
MMR						
or Measles						
or Mumps						
or Rubella						
TB Mantoux Test		Result:		Positive	Negative	
Haemophilus influenza B						
Hepatitis B						
Varicella (chicken pox)						

Physician Signature

Date

THIS FORM MUST BE SUBMITTED NO LATER THAN MAY 31ST.