SummerQuest 2019 Health Form

PLEASE RETURN FORMS VIA: FAX - 978.356.2143 | EMAIL—summerquest@thetrustees.org

MAIL—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 behavioral condition? Special attention includes but is not limited to things like attention deficit disorder, asthma, phobias and bathroom issues. **Yes | No**

If you answered yes, please provide as much detail as possible on a separate sheet.

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

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 _____

Must be in original container with prescription attached. OTC medication must have parent AND doctor's note.

Please circle the medications you would like us to administer when necessary.

Insect Repellant | Itch Cream/Calamine | Sunscreen | Benadryl | Advil or Tylenol (ibuprofen or acetaminophen)

_____ _____

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 JUNE 1ST