STONY BROOK ACRES
PLEASE RETURN TO:
Scantic Valley Y Family Center
45 Post Office Park, Wilbraham, MA 01095-1227

CAMPWEBER/FUNCITY/TEENCAMP
PLEASE RETURN TO:
YMCA of Greater Springfield
275 Chestnut Street, STE 1, Springfield, MA 01104

This side to be filled out by the parent/guardian and checked with physician at time of examination.

Name: _____ Birthdate: _____ Sex: M F Age _____
Last First Middle Initial Please Circle

Parent/Guardian: _____ Home phone: _____

Home Address: _____
Street and number City State Zip Code

Business Address: _____ Business Phone: _____

Second Parent/Guardian: _____ Home phone: _____

Home Address: _____
Street and number City State Zip Code

Business Address: _____ Business Phone: _____

If Parent/Guardian is not available in an emergency, please notify:
Name: _____ Home Phone: _____ Other Phone: _____
Name: _____ Home Phone: _____ Other Phone: _____

Do you carry family medical/hospital insurance? Yes No
Please circle one

If Yes, indicate: Carrier: _____ Policy/Group #: _____

Name of Family Physician: _____ Phone: _____

PARENT/GUARDIAN AUTHORIZATION 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 by me and the examining physician. I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, treatment, and necessary transportation for my child. In the event I cannot be reached in an EMERGENCY I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for my child as named above

Signature_____ Date_____

*** If for religious reasons you cannot sign this form, the camp should be contacted for a legal waiver which must be signed.*

Required information must be determined locally. This is a record of dates of basic immunizations and most recent booster doses.

Vaccines	Year of basic Information	Year of Last Booster
Diphtheria Pertussis (whooping cough) } DPT Tetanus	1. 2. 3.	1. 2.
Tetanus, Diphtheria = TD Or... _____		
Tetanus		
Oral Polio (Sabin) TOPV		
Injectable Polio (Salk)		
Measles (hard measles, red measles, Rubella		
Mumps		
Rubella (German measles, 3-day measles)		
Other		
Tuberculin test given (most recent)		
Hemophilic Influenza b (HIB)		

The applicant is under the care of a physician for the following condition(s): _____

_____

Current treatment (include current medications): _____

_____

_____

Additional Information (including limitations and/or allergies): _____

_____

Medical examination should be performed within 24 months of arrival at camp. Examination for some other purposes within this period is acceptable. I have examined the person herein described and have reviewed his/her health history on _____.It is my opinion that he/she is able to engage in all camp activities, except as noted above.

Licensed Physician's Signature: _____ M.D.

Address: _____City_____State_____ Zip Code_____

Phone: _____Date: _____

_____

*Initial if completed by nurse or physician's assistant