Sanford Day Camps
info@sanfordcamps.com
Fax: 610-565-4764

HEALTHCARE APPRAISAL AND RECORD

ATTENTION! We will no longer accept copies of medical or immunization records due to enhanced HIPPA regulations. Therefore, this form must be completed in full (if question not applicable enter N/A on that line). Parents must sign off on the first page, and the doctor's office must sign off on the second page. Any specific medical/dietary instructions can be submitted on our 'Need to Know' form.

Name ______________________________ Date of Birth _______ Sex _____ Age ____

Parent or Guardian ____________________________________ Best Phone ______________

Address ____ Alternate Phone ______________

City, State, Zip _______________________________________

ALLERGIES | **HEALTH CONDITIONS** (give approx. dates for any health condition)

ALLERGIES		HEALTH CONDITIONS			
Hay Fever	_______	Heart Related	_______	German Measles	_______
Plant	_______	Convulsions	_______	Measles	_______
Insect Stings	_______	Diabetes	_______	Asthma	_______
Food	_______	Ear Infection	_______	Behavior	_______
Drugs	_______	Chicken Pox	_______	Mumps	_______

Surgeries or Serious Injuries ____

Chronic Illness ____

Other Diseases ____

Any Specific Activities To Be Restricted? ____

Provide two (2) emergency contacts (name and phone):

____

____

Specify Hospital of Choice (if no preference, specify NONE): ____

IMPORTANT: Please notify the camp if this camper is exposed to any communicable diseases during the (3) weeks prior to camp attendance.

Parent Authorization This health history is correct so far as I know, and my child named herein has permission to engage in all camp activities on or off premises, except as noted by me or the examining physician on this form. In the event I cannot be reached in an emergency, I hereby give permission to Sanford Camp and medical authorities to transport and medically treat my child.

Parent Signature: ____

Due to the State of Delaware's regulations concerning the operations of children's day camps, we will not permit your child to attend camp if we do not have this COMPLETED form PRIOR to your child appearing at camp.

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INFORMATION REQUESTED ON THIS FORM:
WE DO NOT WANT THE CHILD'S ENTIRE MEDICAL RECORD. PLEASE FILL IN EVERY LINE

Immunization Dates
Required immunizations must be determined locally. This is a record of dates of basic immunizations and recent boosters.

DIP Series ____________
Polio QPV (Sabin) ______
Measles Vaccine (live) ______
Mumps Vaccine ______

Booster ______
Booster ______
Tuberculin ______
Smallpox ______

Tetanus Booster ______
Typhoid ______
German Measles (Rubella) ______
Other ______

General Appraisal Comments: ____

____

(For Girls)
Has this person menstruated? Yes□ No□ If yes, is her menstrual history normal? Yes□ No□
If not, has she been educated as to what to expect? Yes□ No□
Special Considerations: ____

Recommendations/restrictions while in camp:
Special Diet ____
Special drugs/prescriptions Yes□ No□ If yes, name of drug: ____________________
Other ____

I have examined the person herein described and have reviewed his/her health history. It is my opinion that he/she is physically able to engage in camp activities, except as noted above.

______________________________ M.D./D.O./P.A.
Examining Physician

Date: ____________

Doctor's Telephone: ____________

Doctor's Office Address: ______________________________

City/St/Zip ______________________________

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