



Sanford Day Camps

info@sanfordcamps.com

Fax: 610-565-4764

HEALTHCARE APPRAISAL AND RECORD

ATTENTION! This healthcare form must be uploaded into your account. All line items must be answered on this form (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 separate 'Need to Know' form which will be emailed to you about a month prior to the opening of camp.

Name of Camper _____ Sex _____ Age _____ Date of Birth _____
Grade in Fall _____

Parent or Guardian _____ Best Phone _____
Address _____ City _____ State _____ Zip _____

ALLERGIES

Hay Fever _____
Plant _____
Insect Stings _____
Food _____
Drugs _____

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

Heart Related _____
Convulsions _____
Diabetes _____
Ear Infection _____
Chicken Pox _____

German Measles _____
Measles _____
Asthma _____
Behavior _____
Mumps _____

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.



Sanford Day Camps

info@sanfordcamps.com

Fax: 610-565-4764

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. You may attach a separate immunization record.

DIP Series _____	Booster _____	Tetanus Booster _____
Polio QPV (Sabin) _____	Booster _____	Typhoid _____
Measles Vaccine (live) _____	Tuberculin _____	German Measles (Rubella) _____
Mumps Vaccine _____	Smallpox _____	Other _____

General Appraisal Comments: _____

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 _____

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.