

CAMPER LAST NAME _____ FIRST NAME _____ MIDDLE INITIAL _____ DATE OF BIRTH (MM/DD/YYYY) _____

HOME ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____ HOME PHONE NUMBER _____

MOM'S NAME _____ MOM'S CELL PHONE _____ MOM'S WORK PHONE _____ OTHER PHONE/BEEPER _____

DAD'S NAME _____ DAD'S CELL PHONE _____ DAD'S WORK PHONE _____ OTHER PHONE/BEEPER _____

IF NOT AVAILABLE IN AN EMERGENCY, PLEASE NOTIFY:

NAMES: 1. _____ PHONE: _____ CELL: _____

2. _____ PHONE: _____ CELL: _____

ALLERGIES Please list any allergies to medications, foods, insect stings or environmental stimuli. PLEASE describe the reaction your son has when exposed to these allergens. Make special note of any anaphylactic reactions – those that require an EPI Pen.

MEDICATIONS Please list all medications that your son will be taking while at camp. No medications may be sent to Camp Cedar. Prescriptions must all be sent to *Camp Meds* to be packaged and delivered to Cedar. There are no exceptions to this rule.

Medication	Dose	Frequency (circle)		Time(s) to be given (circle)		
_____	_____	Daily	As Needed	Breakfast	Dinner	Bedtime
_____	_____	Daily	As Needed	Breakfast	Dinner	Bedtime
_____	_____	Daily	As Needed	Breakfast	Dinner	Bedtime
_____	_____	Daily	As Needed	Breakfast	Dinner	Bedtime

PARENT AUTHORIZATION

This health form is correct as far as I know, and the person herein described has permission to engage in all prescribed activities, except as noted by the examining physician and me.

I hereby give permission to the medical personnel selected by Camp Cedar to provide routine health care; to administer prescription and over-the-counter medications; to order X-rays, routine tests, treatment, sutures; to release any records necessary for insurance purposes; and to arrange necessary transportation for my child. In the event that I cannot be reached in an EMERGENCY, I hereby give permission to the physician selected by Camp Cedar to hospitalize, secure proper treatment for, and to order injection anesthesia, or surgery for my child as named above. This form may be photocopied for trips out of camp.

Signature: _____ Date: _____

Relationship to Camper: _____

**PAGE 1 of 3 Please complete pages 1 & 2 and return to Camp by June 1st.
Your medical provider should complete Page 3 and it can be sent to Camp separately.**

Name of Camper _____

CHRONIC HEALTH STATES – Please check all that apply. Describe below or attach a separate note to describe any condition that requires special attention by the health care team at camp. This information will be shared with appropriate staff members.

- This camper has no chronic health concerns.
- This camper has the following chronic health concerns:
 - Headaches Seizure Condition Heart Murmur Diabetes Bedwetting
 - Asthma (attach action plan) Sleepwalking Frequent Colds / Infections Lactose Intolerance
 - Knee, Ankle or Back problems Eczema / Hives or Other Skin Conditions
 - Other (please describe) _____

MENTAL, SOCIAL AND EMOTIONAL HEALTH – The information you provide below will be shared with great care among medical staff and camp directors. Other staff members will receive this information only when appropriate and necessary.

This camper has been diagnosed with Attention Deficit Disorder (ADD) or (ADHD)? Yes No

Has this camper been diagnosed with any other specific mental health concern? (i.e. depression, OCD, panic/anxiety disorder) Yes No

Describe: _____

This camper has seen or is currently seeing a professional to address a diagnosed mental health concern? If yes, please explain briefly. Yes No

This camper has a recent emotional health concern (loss, change in family, etc.) Yes
 No
If yes, please explain briefly _____

OVER-THE-COUNTER MEDICATIONS – Camp Cedar stocks many over-the-counter (OTC) medications in tablet, chewable and liquid form. You do not need to send OTC meds to camp. Unless specifically indicated, we will administer OTC meds from our stock. If there are any OTC medications that your son absolutely should **not** have, for example, due to allergy or prescription drug interaction, please list those medications below:

PRIMARY HEALTH CARE PROVIDERS – Please provide the names and phone numbers of your home physicians.

Pediatrician	_____	Phone	_____
Orthodontist	_____	Phone	_____
Dentist	_____	Phone	_____
Mental Health Provider	_____	Phone	_____

CREDIT CARDS – In order to simplify the process in the case of an emergency, medical procedure or prescription, we are asking that you provide us with your credit card information to keep on file. The card will **only** be used under these circumstances and we will **always** contact you before a charge is made.

Name (as it appears on card): _____ Card #: _____
Type of card: _____ Expiration Date: _____ Security Code (on back of card): _____

WHAT HAVE WE FORGOTTEN TO ASK? Please provide any additional information about your son’s health, which may not have been discussed on this form. Attach another sheet if necessary.

**PAGE 2 of 3 Please complete pages 1 & 2 and return to Camp by June 1st.
Your medical provider should complete Page 3 and it can be sent to Camp separately.**

Name of Camper

Date of Birth

Dear Medical Provider,

You are being asked to recommend a camper for participation in a seven week, sleep-away camp program. Camp Cedar is a summer camp for boys aged 8-15 years, located in Casco, Maine. Our program is largely sports and activity oriented. While there is opportunity for highly competitive boys to really push themselves, the emphasis is on teamwork, sportsmanship and athletic development. Our activities include: swimming, diving, water-skiing, basketball, lacrosse, soccer, baseball, ropes and rock climbing, tennis, wrestling and hiking, and others. Our terrain is hilly and we are in the woods in southern Maine. The cabins are not air-conditioned and the boys are routinely exposed to insects, pollens, trees, molds, heat and humidity. If you require any further information about Camp Cedar, or our program before making a recommendation for this camper to participate, please feel free to contact us at: 617-277-8080 during the winter/spring. **After June 1st, we may be contacted at: phone 207-627-4266, fax 207-627-4152.**

IMMUNIZATION HISTORY – Please provide the month and year for each immunization or attach another sheet.

Immunization	Dose 1	Dose 2	Dose 3	Dose 4
Diphtheria, Tetanus, Pertussis - DTP				
Booster: Tetanus, Diphtheria, Acellular Pertussis - Tdap		Must be current within last 5 years		
Meningococcal Vaccine (when recommended by your doctor)		Usually given at 11-12 years of age		
Measles, Mumps, Rubella - MMR			2 doses required for camp	
Pneumococcal Polysaccharide Vaccine - PPV				
Inactivated Poliovirus - IPV / OPV				
Hepatitis A - HepA				
Hepatitis B - HepB				
Haemophilus influenza, type B - Hib				
Varicella - VZ				

MEDICAL RECOMMENDATION

Please note a recent set of baseline Vital signs and any physical findings.

Based on the information presented to me and upon my examination of this child, I recommend him for camp participation. To the best of my knowledge, he has not been exposed to a communicable disease within the last 30 days of my examination.

Signature

Date

Printed Name

Phone

Address