



Camp Attending: _____

Start Date of Camp: _____

Summer Program Medical Information and Waiver

Tremont is required to retain a copy of this form for our records. The information on this form will remain confidential.

Names and addresses will be added to our mailing list, but not released to any other organization.

Please complete this form and return to us at or before registration. It must be signed by both the parent or guardian and an examining physician. **A medical examination is required within one year prior to the camp's starting date.**

Participants without a complete medical form will not be admitted to the program.

CAMPER'S NAME _____ Gender _____

BIRTHDATE _____ RACE _____ Social Security Number _____

PARENT/GUARDIAN _____

HOME ADDRESS _____ City _____ ST _____ ZIP _____

HOME PHONE () _____ WORK PHONE: () _____ FAX: () _____

BEST NUMBER FOR REACHING PARENT OR GUARDIAN WHEN CHILD IS AT TREMONT: () _____

IF NOT AVAILABLE FOR AN EMERGENCY, NOTIFY:

1st alternate-- NAME _____ PHONE () _____ Relationship to Camper: _____

2nd alternate--NAME _____ PHONE () _____ Relationship to Camper: _____

HEALTH HISTORY (Check, giving approximate dates or details on another sheet, if needed)

ALLERGIES

DISEASES

Frequent ear infections _____

Food _____

Chicken Pox _____

Heart Defect/Disease _____

Insect Stings _____

Measles _____

Convulsions _____

Penicillin, sulfa or

German Measles _____

Diabetes _____

other medications _____

Mumps _____

Bleeding/Clotting Disorders _____

Asthma _____

Surgery or Serious Illness (Dates) _____

Chronic or Recurring Illness _____

Other Diseases (or notes on above) _____

Dentist/orthodontist _____ PHONE () _____

Physician _____ PHONE () _____

Is this child covered by medical/hospital insurance? _____ IF SO, INDICATE NAME AND POLICY NUMBER:

CARRIER _____ GROUP OR POLICY NUMBER _____

Are there any activities that should be restricted for this child? _____

IMPORTANT: Please notify the camp if the child is exposed to any communicable disease during the three weeks prior to camp.

Suggestions from Parents: _____

Do we have your permission to give this child Acetaminophen OR Ibuprophen IF NEEDED? _____ Benadryl? _____

LIST ALL MEDICATIONS BROUGHT TO TREMONT: _____

PARENTS 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 physician selected by the camp director to order X-Rays, routine tests, and treatment for the health of my child, and in the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for my child as named above.

It is expressly understood and agreed that GSMIT shall not be responsible or legally liable for any losses of personal property or for any bodily injuries, or the results thereof, incurred and suffered by the applicant or in connection with any activities or programs, unless such loss or injury results directly from the negligent or willful act of an employee of GSMIT acting within the scope of his/her employment.

I grant permission to the Institute to use my child's image, likeness or quotes in publications for the purpose of advertising.

SIGNATURE _____ DATE: _____ rev. March 2010

IMMUNIZATION HISTORY

REQUIRED IMMUNIZATIONS MUST BE CONFIRMED BY YOUR FAMILY DOCTOR OR LOCAL HEALTH DEPARTMENT. PLEASE RECORD THE DATE (MONTH AND YEAR) OF BASIC IMMUNIZATIONS AND MOST RECENT BOOSTER DOSE.

<u>VACCINES</u>	<u>Date of basic immunization</u>	<u>Date of last booster</u>
Diphtheria _____	_____	_____
Pertussis (Whooping Cough) DPT* _____	_____	_____
Tetanus _____	_____	_____
_____ OR _____		
Tetanus _____	_____	_____
Diphtheria TD* _____	_____	_____
_____ OR _____		
Tetanus _____	_____	_____
Oral Polio (Sabin) *TOPV _____	_____	_____
Injectable Polio (Salk)* _____	_____	_____
Measles (Hard measles, red measles, Rubeola) _____	_____	_____
Mumps _____	_____	_____
Rubella (German measles, 3-day measles) _____	_____	_____
Other _____	_____	_____
Tuberculin test given (Most recent) _____	_____	_____
Haemophilus influenza b (HIB) _____	_____	_____
Hepatitis B _____	_____	_____
Chicken Pox _____	_____	_____

MEDICAL EXAMINATION - To be filled out and signed by a licensed physician. **A medical examination is required within one year of the camp's starting date.** Participants without a complete medical form *will not be admitted* to the program. Examination is for determining fitness to engage in strenuous activities.

CODE: V – Satisfactory X - Not Satisfactory (Explain) O - Not examined

Hgt. _____	Wt. _____ lbs.	Hct. or Hgb. Test _____	Urinalysis _____
Eyes _____		Lungs _____	Allergy: (Please specify) _____
Glasses _____		Abdomen _____	_____
Ears _____		Hernea _____	_____
Nose _____		Extremities _____	
Throat _____		Posture (Spine) _____	GENERAL APPRAISAL: _____
Heart _____		Skin _____	
Genitalia _____			_____

For Females:

Has the camper menstruated? _____ If not, has she been told about it? _____
 If so, is her menstrual history normal? _____ Special Considerations _____

RECOMMENDATIONS AND RESTRICTIONS WHILE IN CAMP:

Special diet? _____
 Medications? _____

 Is the camper allowed to swim? _____
 Is there a limit to strenuous activity? _____
 Other _____

I HAVE EXAMINED THE PERSON HEREIN DESCRIBED AND HAVE REVIEWED THE HEALTH HISTORY. IT IS MY OPINION THAT THIS CAMPER IS PHYSICALLY ABLE TO ENGAGE IN CAMP ACTIVITIES, EXCEPT AS NOTED ABOVE.

Physician _____ Phone () _____ Date _____
 Address _____ City _____ ST _____ Zip _____