New Heights Camp
Health Evaluation Form)

New Heights Summer Camp requires that this health evaluation be completed and signed by a licensed physician and that it be on file at camp at the time of attendance. The participant or participant's parent/guardian (if participant is a minor) must sign this form before he or she may participate in *any* activities at *New Heights* . All information will be kept confidential and will only be shared with camp directors, nurse, and other persons when deemed necessary.

OFFICE USE ONLY
Date Rec'd
Participant
Volunteer Staff

Health Staff Comments:

Participant Information

Name______________________________ (Circle): Male / Female
First Name Middle Initial Last Name

Home address______________________________
Street Address City State/Province Zip/Postal Code

Home phone (______)______________________Work or additional phone (_____)____________________

Social security #______________________Date of birth ______________Age at camp__________

Parent(s)/guardian(s) names (If participant is a minor):______________________________

Parent Home phone & Work phone if different than above:______________________________

Emergency Contact

Person to contact in emergency (In addition to parent/guardian)______________________________

Address of emergency contact ______________________Phone number (_____)____________________

Physician's name______________________Physician's Phone number (_____)____________________

Insurance Information (Please attach a copy of insurance card or form.)

Is the participant covered by family medical/hospital insurance? Circle: **YES** / **NO** (If NO, see below)

If **YES**, indicate carrier or plan name______________________Group ______________________

Carrier address______________________Carrier phone number (_____)____________________

Name of insured______________________Relationship to participant____________________

Social security number of policy holder or insurance ID number______________________________

Please read and sign the following: I understand that *New Heights Summer Camp* **does not** provide personal medical or health insurance and that I am personally responsible for any expenses incurred as a result of illness or injury while at *New Heights Summer Camp*.

Signature of participants over 18 years of age or parent/guardian (for minors)______________________________

Medications Being Taken (Please list ALL medications, including over-the-counter or nonprescription drugs, taken routinely. No medications should be brought to camp except prescription or allergy medications, i.e., no aspirin, Tylenol, etc. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician, the name of the medication, the dosage, and the frequency of administration. Vitamins may be brought, but must be turned in and dispensed by health care personnel.)

Does the participant take medications? (Circle): **YES / NO** If **YES,** please list and describe medications below. (*Participants taking medication for emotional or mental health should have a history of taking the same medication at the same dose for three months prior to camp.)

Name of Medication	Dosage	Specific times taken each day	Reason for taking
Med #1			
Med #2			
Med #3			

YOUTH CAMP HEALTH EXAM/RECORD
FOR CAMPERS AND STAFF

Physical Exams Are Valid For 3 Years
From Date of Last Examination

☐ Camper
☐ Staff

Please Return Completed Form to the Camp

Name________________________ Date of Birth____________ Phone____________

Guardian____________________ Address________________________

Emergency Contact________________________ Telephone____________

Date of Arrival at Camp: ____________________ Departure Date:____________________

TO BE COMPLETED BY THE SPECIFIED MEDICAL PRACTITIONER:

Date of Exam ____/____/____

________ May participate in all camp activities

________ May participate except for: ________________________________

Medical information pertinent to routine care and emergencies:________________________

Is this individual taking prescription or over the counter medication(s)? ☐ YES ☐ NO If yes, indicate names of medication(s):____________________________

Does the individual have allergies? ☐ YES ☐ NO Explain: ____________________

Is the individual on a special diet? ☐ YES ☐ NO Explain: ____________________

Does the individual have special needs? ☐ YES ☐ NO Explain: ____________________

This camper/staff is up-to-date on all the following routine childhood immunizations currently recommended by the American Academy of Pediatrics and National Advisory Committee on Immunization Practices:

	Yes	No		Yes	No
Measles			Hepatitis B		
Mumps			Diphtheria		
Rubella			Pertussis		
Chickenpox			Polio		
Tetanus					

Comments: ____

Print name of medical care provider: ________________________

Medical care provider's address: ________________________

Medical care provider's: City/Town______________ ST______ Zip Code______

Physician Stamp

____
Signature of Physician, PA, APRN or RN

____
Date Form Signed

____
Telephone Number

Note to Physician: The New Heights Summer Camp, for which this person is applying, is a residential summer program and consists of rigorous daily activity, which may include swimming, canoeing, basketball, volleyball and high ropes. Each participant is encouraged to engage in all activities.

I hereby certify that the foregoing is a full, true and correct record of an examination of the person named herein, conducted by me on the day of the date hereof. I hereby further certify that it is my opinion, based upon such examination and upon the accompanying medical history, that the health of this person is such that he/she may participate in the activities at Camp. I see no evidence that the person named herein would be a danger to himself or others as a participant in New Heights Summer Camp.

Restrictions
(Provide specific instructions concerning any dietary restrictions or limitations or adaptations to activity that are necessary.)
Note: It is the responsibility of the participant to manage dietary restrictions and activity limitations and/or adaptations.

Additional Health Information
(Provide any additional information about the participants' behavior and physical, emotional, or mental health about which the camp should be aware.)

Allergies (List all known.)

Medication allergies (list):

Describe reaction and management of the reaction:

Food allergies (list):

Describe reaction and management of the reaction:

Other allergies (list – including insect stings, hay fever, asthma, etc.):

Describe reaction and management of the reaction:

Consent

IMPORTANT for minors: In case of illness or accident during the trip to and from the New Heights Summer Camp, or while at camp, and when New Heights is unable to contact us through reasonable effort, we the parents/guardians of ______________________________, hereby consent to the giving of any and all emergency medical care to our child named above that may be deemed necessary by an official of the Camp in consultation with any physician or hospital without obtaining further consent. I agree to the release of any records necessary for treatment, referral, billing or insurance purposes.

Parent/guardian's signature Date

Form Checklist

- ❑ Have you filled out the form completely?
- ❑ Have you obtained physician's signature?
- ❑ **Have you obtained parental/guardian signatures**? (for minors)
- ❑ Have you attached a copy of insurance card or claim form if covered by medical/health insurance?

All Health Evaluation Forms are valid for 3 years from the date of the LAST EXAMINATION
Please copy this form before sending it to New Heights Summer Camp

Please submit this completed Health Evaluation Form to Camp Director at
PO Box 662 Mohegan Lake, NY 10547 before arrival at camp.

Please *do not mail any* documentation within one week of the beginning of camp.