PLEASE RETURN TO: BOB NEWELL, Director of Camp Smile 47 WESTGATE DRIVE ROCHESTER, NY 14617

This form is used solely for Camp Smile staff and will not be disseminated to any other party!

CAMP SMILE HEALTH INFORMATION FORM

Name:	Birthda	te: Sex: Age:
Parent or Guardian:		Phone:
Home Address:		Zip:
Business Address:		Zip:
If not available in an emergency, notify	:	
1. Name:	Phone:	
Address:		
2. Name:	Phone:	
Address:		
Check & list approximate dates:		
Health history:	Allergies:	Diseases:
Frequent ear infections	Hay Fever	Chicken Pox
Heart defect/disease	Ivy Poisoning	Measles
Seizures	Insect Stings	German Measles
Diabetes	Penicillin	Mumps
Bleeding/clotting disorders	Foods	
Asthma	Medications	
Operations or serious injuries (please in	dicate dates):	
Chronic or recurring illnesses:		
Name of primary physician:		Phone:
Name of ophthalmologist:		Phone:
Name of dentist:		Phone:
Do you carry family medical/hospital in	nsurance (circle one): YES N	0
If so, indicate carrier:		_ Policy or group #:
Any specific activities to be encouraged	l:	
Or restrictions:		

IMPORTANT: Please notify the camp if this camper/counselor was exposed to any communicable disease during the 3 weeks prior to camp attendance.

Immunization history: must be completed prior to attendance at campVaccines:Date of last booster:

DPT				
MMR				
OPV				
Hepatitis B				
Tetanus				
Influenza B				
Varicella				
Last vision screen: Left	Right			
Nature of your child's visual impairment:				
Is this child on medication? Explain:				
Is the parent sending the medication to camp?				
Special diet?				

Important: must be completed for attendance at CAMP SMILE:

Parent/Guardian authorizations: 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 or the primary care physician.

I, the undersigned parent/legal guardian of the above, a minor, do hereby give permission to the physician selected by the camp director to order x-rays, routine tests and treatments 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.

(Required) Signature of Parent/Guardian

Witness

AUTHORIZATIONS

I DO HEREBY AGREE to hold the "Camp Smile" staff, and the	ose involved in its program, blameless
from any and all claims while my child	is participating in the "Camp Smile"
program.	

DATE:

Signature of Parent and/or Guardian

I DO HEREBY GIVE my child ______ permission to go swimming with CAMP SMILE. Listed below are any restrictions such as water temperature or devices, which need to be removed before swimming.

Swimming restrictions:

DATE:

Signature of Parent and/or Guardian

I DO HEREBY GIVE to CAMP SMILE use of my child's likeness for advertising purposes for CAMP SMILE. For example, pictures for any future brochures, use on our website or in public presentations done by our Camp Smile Committee or Directors.

DATE:

Signature of Parent and/or Guardian