PLEASE RETURN TO: **JANE LYTH, Director of Camp Smile**
581 BEACH AVENUE
ROCHESTER, NY 14612

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

CAMP SMILE HEALTH INFORMATION FORM

Name: _____ Birthdate :_____ 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:
Frequent ear infections_____
Heart defect/disease _____
Seizures _____
Diabetes _____
Bleeding/clotting disorders _____
Asthma _____

Allergies:
Hay Fever _____
Ivy Poisoning _____
Insect Stings _____
Penicillin _____
Foods _____
Medications _____

Diseases:
Chicken Pox _____
Measles _____
German Measles _____
Mumps _____

Operations or serious injuries: please indicate dates: _____

Chronic or recurring illnesses: _____

Name of primary care physician:_____ Phone:_____

Name of ophthalmologist:_____ Phone:_____

Name of dentist: _____ Phone:_____

Do you carry family medical/hospital insurance: Circle one: YES NO

If so, indicate carrier: _____ Policy or group #_____

Any specific activities to be encouraged:_____

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 camp

Vaccines:	**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 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 names above.

_____ _____

(Required) Signature of Parent/Guardian ***Witness***

_____

Date

AUTHORIZATIONS

I DO HEREBY AGREE to hold the "CAMP SMILE" staff, and all those 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
