



**Please Mail or Fax to:**  
**Pine Brook Camp**  
 210 Lakeview Road  
 Shutesbury, MA 01072  
 Phone: (413) 367-2643  
 FAX: (413) 367-2140

# Health and Medical Form

This form must be completed in order for campers and staff to attend camp

## GENERAL INFORMATION

Name \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_  Male  Female

Address \_\_\_\_\_ Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Grade completed (youth only) \_\_\_\_\_

Mother (or Guardian) \_\_\_\_\_ Work No. \_\_\_\_\_ Cell No. \_\_\_\_\_

Father (or Guardian) \_\_\_\_\_ Work No. \_\_\_\_\_ Cell No. \_\_\_\_\_

**Emergency Contact – If a parent is not available, please notify:**

Name \_\_\_\_\_ Relation \_\_\_\_\_ Cell No. \_\_\_\_\_

Address \_\_\_\_\_ Phone No. \_\_\_\_\_

Insurance Company \_\_\_\_\_ Policy Number \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone No. \_\_\_\_\_

Dentist/orthodontist \_\_\_\_\_ Phone No. \_\_\_\_\_

## MEDICAL HISTORY

Are you now, or have you ever been treated for any of the following:

Y	N	Condition	Explain	Y	N	Condition	Explain
		Asthma				Sickle cell disease	
		Diabetes				Fainting spells	
		Hypertension (high blood pressure)				Seizures	
		Heart disease (CHF, CAD, MI)				Sleep disorders (sleep apnea)	
		Stroke/TIA				GI problems (abdominal, digestive)	
		COPD				Surgery	
		Ear/sinus problems				Serious Injury	
		Psychiatric/psychological disorders				Chicken Pox	
		Emotional difficulties				Measles	
		Learning disorders (ADHD, ADD)				Mumps	
		Bleeding disorders				Allergies	
		Thyroid disease				Other	
		Kidney disease				Other	

Do you take any MEDICATIONS?  YES  NO If YES, A MEDICATION RECORD FORM must be filled out

Do you have any food allergies or dietary restrictions? Please list: \_\_\_\_\_

Do you receive any special accommodation at school? (ie: 1:1 aide, preferential seating, behavior modifications) If so, please explain: \_\_\_\_\_

## PERMISSION - SIGNATURE REQUIRED

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.

- **Authorization for Treatment:** I hereby give permission for the camp nurse to administer medications and treatment for my child as named above, including non-prescription medications for mild illness as well as the prescriptions brought with the child. *In the event I cannot be reached in an emergency,* I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, and to order injections, anesthesia or surgery for my child as named above.
- I give permission for the camp counselor to help apply sunscreen on my child's back where they cannot reach, as well as bug repellent when needed
- I give permission for the camp to take pictures and video of me/my child to use for promotional material, website and camp related social media posts.

Signature of parent or guardian or adult camper or staff

Date

# IMMUNIZATION HISTORY

Written documentation of immunization or alternative proof of immunity is required for all campers and staff members. Please fill in the chart below or attach a copy of all immunizations.

vaccine	Date/type	Vaccine	Date/type	Vaccine	Date/type	Vaccine	Date/type
<b>Hepatitis B</b> (HepB, HepB-Hib, DTaP-HepB-IPV)	1	<b>Haemophilus influenzae type b</b> (Hib, HepB-Hib, DTaP-Hib)	1	<b>Polio</b> (IPV, DTaP-HepB-IPV)	1	<b>Pneumococcal Polysaccharide</b>	1
	2		2		2		2
	3		3		3		<b>Influenza</b> Inactivated (Intramuscular) or
4	4		4		2		
<b>Diphtheria, Tetanus, Pertussis</b> (DTaP, DT, DTaP-Hib, Dtap-HepB-IPV,Td)	1	<b>Measles, Mumps</b>	1	<b>Pneumococcal Conjugate</b> (PCV7)	1	<b>Other:</b>	3
	2		2		2		
	3	<b>Varicella</b> (var)	1		3		
	4		2		4		
	5		1				
	6	<b>Hepatitis A</b> (HepA)	1				
	7		2				

**\*\*\*\*\*Medical Examination to be completed by a license physician\*\*\*\*\***

## MEDICAL EXAMINATION

This examination must be performed within 18 months of arrival at camp. Examination for some other purpose within this period is acceptable. (If camper or staff has had an exam within 18 months, attach a copy of that exam to this form, or bring it with you to camp on registration day). Examination is for determining fitness to engage in strenuous activities.

Blood Pressure: \_\_\_\_\_ Pulse: \_\_\_\_\_

	Normal	Abnormal	Explain any abnormalities	Range of Mobility	Normal	Abnormal	Explain any abnormalities
Eyes				Knees (both)			
Ears				Ankles (both)			
Nose				Spine			
Throat							
Lungs				<b>Other</b>	<b>Yes</b>	<b>No</b>	
Heart				Contacts			
Abdomen				Dentures			
Genitalia				Braces			
Skin				Inguinal hernia			<b>Explain</b>
Emotional adjustment				Medical Equipment (i.e., CPAP, oxygen)			

## RECOMMENDATIONS AND RESTRICTIONS WHILE AT CAMP:

Special Diet/Food Allergies \_\_\_\_\_

Restrictions \_\_\_\_\_

Other \_\_\_\_\_

I have examined the person herein described and have reviewed his health history. It is my opinion that he/she is physically able to participate in camp activities, except as noted above.

\_\_\_\_\_  
Licensed Physician's Signature

\_\_\_\_\_  
Date

Address \_\_\_\_\_

Phone \_\_\_\_\_