



# Medical Information Form Summer Recreation Camps

## Personal Information

Camper's Name		Birth Date		Social Security No.	
Family Physician	Phone No.	Family Dentist	Phone No.		
Medical Insurance Provider		Policy No.		Group No.	

## Immunization History

Month / Year	DTP (Diphtheria, Tetanus, Pertussis)	Month / Year	HIB (Hemophilus Influenza)
Month / Year	OPV (Polio Oral) / IPV (Polio Injected)	Month / Year	MMR (Measles, Mumps, Rubella)

**Please indicate if your child is taking any medications.  
NOTE: Camp staff is not permitted to dispense medication.**

Medication	Reason for Taking	Dosage	Time Taken
Medication	Reason for Taking	Dosage	Time Taken

**Please indicate if you child has, or has ever had, any of the following conditions:**

Y	N	Abdominal Pain	Y	N	Fatigue (chronic)	Y	N	Mononucleosis
Y	N	Anemia	Y	N	Head Injury	Y	N	Pneumonia
Y	N	ADD, ADHD	Y	N	Headaches (recurrent)	Y	N	Seizures
Y	N	Asthma	Y	N	Hearing Loss	Y	N	Sinus Infections
Y	N	Bronchitis	Y	N	Heart Disease, Murmur	Y	N	Skin Disorders
Y	N	Congenital Abnormality	Y	N	Hepatitis	Y	N	Tuberculosis
Y	N	Cancer	Y	N	High Blood Pressure	Y	N	Vision Problems
Y	N	Depression	Y	N	Immune Disease	Y	N	Urinary Tract Infection
Y	N	Diabetes	Y	N	Kidney Disease			
Y	N	Ear infections (chronic)	Y	N	Migraines			

Please complete the opposite side of this form

**Please indicate if you child has, or has ever had, any of the following conditions and provide an explanation:**

Y	N	Allergies to medications	
Y	N	Other allergies	
Y	N	Prior hospital admissions	
Y	N	Surgeries	
Y	N	Knee/ankle injuries requiring medical attention	
Y	N	Serious injuries that did not require hospitalization	
Y	N	Broken bones, fractures, or other dislocations	
Y	N	Unexplained loss of consciousness	
Y	N	Excessive absenteeism from school due to illness	
Y	N	Restricted physical activity due to illness or injury within 3 years	
Y	N	Treatment or counseling for any emotional or psychiatric problem within 3 years	
Y	N	Physical or emotional disability	
Y	N	Any other significant past medical history	
Y	N	Family or lifestyle changes within the past year	

**Please provide any other pertinent medical information**

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**Medical Release Statement**

I hereby give my permission to the medial personnel selected by New Castle County and/or the Summer Recreation Camp Staff to order treatment and necessary transportation for my child on a routine or emergency basis. In the event I cannot be reached in an emergency, I hereby give my permission to the physician to secure and administer treatment, including authorization for my child named above.

I give my permission for New Castle County and/or the Summer Recreation Camp Staff to release and receive protected health information regarding my child in the event that the information is required for the completion of medical records and referrals made, but not limited to, consultants, labs, and hospitals involved in my child's care.

Parent / Guardian Name	Parent / Guardian Signature	Date