

Child's Name _____ (please print)

Last

First

S A N D W I C H

COMMUNITY SCHOOL Summer Camps 2010
365 Quaker Meetinghouse Road, E. Sandwich, MA 02537

508-888-5300|scslearn.org|508-888-8095 fax

In accordance with 105 CMR: DEPARTMENT OF PUBLIC HEALTH 8/15/03 105 CMR – 1715 105 CMR 430.000: MINIMUM STANDARDS FOR RECREATIONAL CAMPS FOR CHILDREN (STATE SANITARY CODE, CHAPTER IV), Sections: 430.150: Health Records; 430.151: Physical Examinations by Physician and Certificate of Immunization; 430.152: Required Immunizations; this form (both sides) must be completed and returned to the Community School office prior to the start of your child's summer camp.

Camp(s) **Week 1** _____ **Week 2** _____ **Week 3** _____
Extended Camp Day? Yes No **Extended Camp Day?** Yes No **Extended Camp Day?** Yes No

Week 4 _____ **Week 5** _____ **Week 6** _____
Extended Camp Day? Yes No **Extended Camp Day?** Yes No **Extended Camp Day?** Yes No

Name of Child _____ Date of Birth _____ Age _____ Gender M/F _____
Parent/Guardian _____ Day Phone _____ Cell Phone _____
Street Address _____ City _____ State _____ Zip _____
Name 2nd Parent/Guardian _____ Day Phone _____ Cell Phone _____
Street Address _____ City _____ State _____ Zip _____

Emergency Contact (1) (Someone other than Parents in case parents cannot be reached)

Name _____ Relationship to Camper _____
Day Phone _____ Cell Phone _____

Emergency Contact (2) (Someone other than Parents in case parents cannot be reached)

Name _____ Relationship to Camper _____
Day Phone _____ Cell Phone _____

Dietary restrictions _____
Other diseases _____

Please describe any current physical, mental or psychological conditions requiring medication, treatment or special restrictions or consideration while at camp _____

Current Doctor _____ Phone with Area Code _____

Allergies

- Hay Fever _____ Asthma _____
- Poison Ivy, etc. _____ Penicillin _____
- Other Drugs _____ Other _____
- Foods _____
- Insect Bites/Stings _____

Insurance Information Do you carry family medical/hospital insurance? ___ Yes ___ No

Insurance Carrier: _____ Policy Holder: _____ Insurance No. _____

This health history is correct so far as I know, and the child herein described has permission to engage in all prescribed camp activities except as noted. Authorization for Treatment: I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, treatment, and necessary related transportation for me/or my 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, for the person named above.

Signature _____ Date Signed: _____

I give the Sandwich Community School permission to use my child's photograph or video for the purpose of advertising and or promotion of its' program. Yes _____ No _____

I give the Sandwich Community School permission to use my child's original artwork for the purpose of advertising and or promotion of its' programs including but not limited to brochures, newspaper ads, and website. Yes _____ No _____

Signature _____ Date Signed: _____

The Sandwich Community School Summer Camps must comply with Regulations of the Massachusetts Department of Public Health and be licensed by the Sandwich Board of Health.

This side is to be completed by a licensed physician.

Parents: You must provide the Sandwich Community School with an immunization history for your child and proof of a physical examination conducted by a physician within the last 24 months (24 months prior to the start of date of your child's camp.) You may attach a copy of the physician's record to this form or have your physician complete the following.

Child's Name: _____

Immunization History

Please record the date (month and year) of basic immunizations.

Immunizations	Year of Basic Immunization	Booster
Diphtheria	1	1
Pertussis (Whooping Cough) }DPT* Tetanus Or	2 3	2
Tetanus Diphtheria } TD* or		
Tetanus		
Oral Polio (Sabin) * TOPV		
Injectable Polio (Salk)		
Measles (hard measles, red measles, Rubeola)		
Mumps		
Rubella (German measles, 3-day measles)		
Other		
Tuberculin test given _____ (most recent)		
Haemophilus influenza b (HIB)		
Hepatitis B		

Health Care Recommendations by Licensed Physician

I have examined the above camp applicant within the past 24 months. Date examined _____

In my opinion, the child listed above is able to participate in an active camp program with the following limitations:

Height _____ Weight _____ Blood Pressure _____

Is the individual under the care of a physician for any condition or impairment which may affect the individual's activities while attending the camp?

Please explain (include treatment and current medications)

Does applicant have epilepsy? _____ Yes _____ No Does applicant have diabetes? _____ Yes _____ No

Allergies (food, drug, plant, insect, etc.) _____

Recommendations and Restrictions while at Camp

Please list any camp activities from which the individual should be exempted for health reasons

Please describe any current physical, mental or psychological conditions requiring medication, treatment or special restrictions or consideration while at camp _____

Medical Information pertinent to routine care and emergencies

I have examined the person herein described and have reviewed her/his health history within the last 24 months. It is my opinion that she/he is physically able to engage in any camp activity except as noted above.

Examining Physician (Please Print): _____ Date Physical Performed: _____

Physician's Signature: _____ Date Signed: _____

Address: _____ Phone Number /Area Code: _____

Date of Form

Completion _____ *by _____

*Initial if completed by nurse or physician's assistant