

SUMMER DAY CAMP 2010 REGISTRATION FORM



PLEASE CHECK WEEK OR WEEKS REQUESTED (LIMIT 2 WEEKS)

<input type="checkbox"/> July 12-16	<input type="checkbox"/> Aug 2 - 6
<input type="checkbox"/> July 19-23	<input type="checkbox"/> Aug 9 - 13
<input type="checkbox"/> July 26-30	<input type="checkbox"/> Aug 16-20
	<input type="checkbox"/> Aug 23-27

**Learning Center at
Overlook Farm**
216 Wachusett St., Rutland, MA
(508) 886-2221
(508) 886-5038 fax
overlook.farm@heifer.org
www.heifer.org/overlook

For Office Use Only:

- Payment Received
- Cash
- Check # _____
- VISA MC
- Waiver Received
- Immunization Form .
- Confirmation Sent

Cost per week: \$200	Please make checks payable to "Heifer International." Payment is nonrefundable.	Camp Session(s) \$ _____
Camp Hours: 9:00—4:00 pm		Extended Care \$ _____
Do you require extended care? Yes <input type="checkbox"/> No <input type="checkbox"/>		Total Enclosed \$ _____
Morning <input type="checkbox"/> (8:30-9:00 am) \$25 per session	Afternoon <input type="checkbox"/> (4-5:30 pm) \$25 per session	Both <input type="checkbox"/> \$50 per session
Please add the extended care amount to your camp session payment at time of registration.		
Please charge my <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard # _____ expiration date: _____		
Name as it appears on the card: _____		
Billing address if different from camper's address: _____		

This form must be filled out completely as required by law. This health form must be completed, signed and returned to Heifer Learning Center at Overlook Farm at least two weeks prior to the camp session. Parents/Guardians of campers arriving at camp without, or with an incomplete, form will be contacted to pick up their children.

The information contained in this health form is used to advise our day camp coordinator of your camper's current condition and special needs. It also contains the contact information that we will use in the case of an accident or emergency. Information on this form is confidential and will be shared with staff only as appropriate.

SECTION A – General Camper Information

Camper's Name: _____ DOB: _____

Address _____ Age @ camp: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Gender: M / F

Mother's Name: _____ (or Guardian)
Day Phone: _____ Cell Phone: _____

Father's Name: _____ (or Guardian)
Day Phone: _____ Cell Phone: _____

Email address: _____ Email address: _____

EMERGENCY CONTACT

When parents cannot be reached, who should we contact in case of an emergency?

Name: _____ Cell Phone: _____

Address: _____ Relationship: _____

PICK UP AUTHORIZATION

Please list two additional people (besides mother, father or guardian listed above) who are authorized to pick up your child at camp. We will require picture identification and we will only release your child to the people named on this sheet.

1. _____ Phone _____

2. _____ Phone _____

Section B – Health History

Allergies

<i>Mark all known</i>	Specifics	Reaction	Treatment
<input type="checkbox"/> Plants/Pollen			
<input type="checkbox"/> Insect Stings			
<input type="checkbox"/> Food			
<input type="checkbox"/> Medications			
<input type="checkbox"/> Animals			
<input type="checkbox"/> Other			

General Questions (Explain “yes” answers below)

Has/does the participant:

	Yes	No		Yes	No
Had any recent injury, illness or infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>	Ever been diagnosed with a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>
Have chronic or recurring illness/conditions?	<input type="checkbox"/>	<input type="checkbox"/>	Ever had back problems?	<input type="checkbox"/>	<input type="checkbox"/>
Ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	Ever had problems with joints (e.g., knees, ankles)?	<input type="checkbox"/>	<input type="checkbox"/>
Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	Bring an orthodontic appliance to camp?	<input type="checkbox"/>	<input type="checkbox"/>
Have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>	Have a skin problem (itching, rash, acne)?	<input type="checkbox"/>	<input type="checkbox"/>
Ever had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>	Have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
Ever been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	Have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
Wear glasses, contacts or protective eyewear?	<input type="checkbox"/>	<input type="checkbox"/>	Had mononucleosis in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
Ever had frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>	Had problems with diarrhea/constipation?	<input type="checkbox"/>	<input type="checkbox"/>
Ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Had problems with sleepwalking?	<input type="checkbox"/>	<input type="checkbox"/>
Ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Had an abnormal menstrual history?	<input type="checkbox"/>	<input type="checkbox"/>
Ever had seizures?	<input type="checkbox"/>	<input type="checkbox"/>	Had a history of bed-wetting?	<input type="checkbox"/>	<input type="checkbox"/>
Ever had chest pain during or after exercise:	<input type="checkbox"/>	<input type="checkbox"/>	Ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
Ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	Ever had emotional difficulties for which professional help was sought?	<input type="checkbox"/>	<input type="checkbox"/>

Please explain any “yes” answers, noting the number of the questions:

Section B – Health History continued

Immunization History

Please attach a physician signed certificate of immunizations.

Required Immunizations (per the Massachusetts Department of Public Health)

1. **Measles, Mumps and Rubella (MMR) Vaccine:** At least one dose of MMR Vaccine must be administered at or after 12 months of age or there must be proof of laboratory evidence of immunity.
 - A second dose of live measles containing vaccine is required for all campers of any age.
 - Both doses of measles vaccine must be given at least one month apart, and be given at or after 12 months of age, or laboratory evidence of immunity.
2. **Polio Vaccine:** At least three doses of either trivalent oral polio vaccine (OPV) or enhanced potency inactivated polio vaccine (e-IPV) are required. If a mixed schedule of polio vaccine is given (IPV and OPV), a total of 4 doses are required.
3. **Diphtheria and Tetanus Toxoids and Pertussis Vaccine:** At least four doses of DtaP/DTP/DT/Td are required. (the pertussis component is not given to anyone seven years of age or older). A booster dose of tetanus/diphtheria, adult type toxoid (Td) is required if more than ten years have elapsed since last dose.
4. **Hepatitis B:** For all children born on or after January 1, 1992, three doses of Hepatitis B vaccine are required.

Additional Health Information

Are there any specific activities to be restricted, limited, or adapted?

Specify any dietary restrictions or needs:

Please tell us any additional information about your camper's behavior and physical, emotional, or mental health which will be useful to our camp health care and/or camp staff:

If your camper has any needs that will require special accommodation while at camp, please call the Day Camp Coordinator at 508-886-2221. Thank you.

Section C – Consent and Permission to Treat

This health history is correct and complete so far as I know. I hereby give my permission to the **designated health care personnel - including an off site health care consultant and on site health care supervisor** - selected by the camp to provide routine health care, administer prescribed and over-the-counter medications as noted, and to seek emergency medical treatment for my child/ward.

In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization for the person herein described. I authorize the medications I have listed to be administered by the Health Care Supervisor, as directed to the minor camper for whom it was prescribed.

Signature of Parent/Guardian: _____

Printed Name: _____

Date: _____

Medical Information

Name of Family Physician: _____ Phone: () _____

Name of Dentist/Orthodontist: _____ Phone: () _____

Medical/hospital insurance _____

Policy or Group # _____

Name of insured: _____ Relationship to camper: _____

MEDICAL AUTHORIZATION to administer medication at camp

If your camper needs to have prescribed medication administered during camp hours, this section must be signed by the prescribing physician.

List any medication your camper is bringing to camp, its use and dosage.

All medication must be brought in its original container with the completed pharmacy label and must have specific instructions for use (camper's name, dosage, #of pills, prescribing practitioner, pharmacy name & address). Please add additional sheet of paper if needed.

Medication #1 _____ Dose: _____ Time to administer: _____

Reason for taking: _____ Side effects: _____

Medication #2 _____ Dose: _____ Time to administer: _____

Reason for taking: _____ Side effects: _____

Please attach a separate page if more than two medications are prescribed.

Prescribing Doctor: _____

Signature: _____ Date: _____

Please identify any medications taken during the school year that camper does/may not take during the summer:

Please Note: Heifer Learning Center at Overlook Farm has a health center (infirmary) that will be stocked with basic first aid supplies. Overlook Farm staff will not administer ANY form of over-the-counter or prescribed medication without receiving the completed form above.