RED ROBIN
COUNTRY DAY
SCHOOL+CAMP

Developed and Approved by the American Camp Association with the American Academy of Pediatrics

Mail to the address below by ___/___/___ (Date)
Red Robin Country Day School & Camp
878 Jericho Turnpike
Westbury, NY 11590

Phone 516.334.1144
Fax 516.334.0565

Information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care. (*This side to be filled out by parents/guardians of minors or by adult campers/staff members themselves.*)

Name _____ / _____ / _____ Date of Birth ___/___/___ Sex____ Age____
Last First MI

Parent or Guardian (or Spouse) _____

Home Address _____ / _____ / _____ / _____ Phone ( ) _____
Street & Number City State Zip Area/Number

Business _____ / _____ / _____ / _____ Phone ( ) _____
Street & Number City State Zip Area/Number

Second Parent or Guardian or Emergency Contact _____

Home Address _____ / _____ / _____ / _____ Phone ( ) _____
Street & Number City State Zip Area/Number

Business _____ / _____ / _____ / _____ Phone ( ) _____
Street & Number City State Zip Area/Number

If not available in an emergency, please notify

Name _____

Address _____ / _____ / _____ / _____ Phone ( ) _____
Street & Number City State Zip Area/Number

Health History
(Check. Give approximate dates.)
__ Frequent Ear Infections
__ Heart Defect/Disease
__ Convulsions
__ Diabetes
__ Bleeding/Clotting Disorders
__ Hypertension
__ Mononucleosis

Diseases
__ Chicken Pox
__ Measles
__ German Measles
__ Mumps

Allergies (Dates not needed)
__ Hay Fever
__ Ivy Poisoning, etc.
__ Insect Stings
__ Penicillin
__ Other Drugs
__ Asthma
__ Other
(Specify)_____
_____

Operations or serious injuries (dates)_____
Chronic or recurring medical illness or condition_____
Dietary restrictions_____
Current medications (send with instructions)_____
Other diseases_____
Name of dentist/orthodontist _____ Phone ( ) _____
Name of family physician _____ Phone( ) _____
Do you carry family medical/hospital insurance? ☐Yes ☐No
If so, indicate: Carrier_____ Policy or Group #_____
Suggestions on health related information for camp personnel_____
_____
For Female:
Has this person menstruated?_____ If not, has she been told about it?_____
If so, is her menstrual history normal?_____ Special Considerations_____

Important – This Box Must be Completed for Attendance*
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 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. The completed forms may be photocopied for trips out of camp.

Signature of parent or guardian or adult camper/staffer
X _____

Witness **X** _____ Date ___/___/___

I also understand and agree to abide by the restrictions placed on my camp activities.
Signature of minor **X** _____

*If for religious reasons you cannot sign this, then the camp should be contacted for a legal waiver, which must be signed prior to attendance.

Immunization History
Required immunizations must be determined locally. Please record the date (month and year) of basic immunizations and most recent booster doses.

Vaccines	Year of Basic Immunization	Year of Last Booster
Diphtheria Pertussis (Whooping Cough) Tetanus or } DPT*	1 2 3	1 2
Tetanus Diphtheria or } TD*		
Tetanus		
Oral Polio (Sabin)* TOPV		
Injectable Polio (Salk)		
Measles (hard measles, red measles, Rubeola)		
Mumps		
Rubella (German measles, 3-day measles)		
Other		
Turberculin 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 two years Date Examined ____ / ____ / ____

In my opinion, the above's condition ☐ does ☐ does not preclude his/her participation in an active camp program.

Height_____ Weight _____ Blood Pressure_____

The applicant is under the care of a physician for the following condition(s) _____

_____

_____

Current treatment (include current medications)_____

_____

Explanation of any reported loss of consciousness, convulsion or concussion

_____

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

Recommendations and Restrictions While at Camp

Any treatment to be continued at camp_____

Any medication(s) to be administered at camp (specific dosages)_____

Any medically prescribed meal plan or dietary restrictions_____

Any allergies (food, drugs, plants, insects, etc.) _____

Activities to be encouraged or limited _____

Additional Health Information _____

Licensed Physician's Signature X _____

Address _____ / _____ / _____ / _____ Phone ( ) _____
Street & Number City State Zip Area/Number

Date of Form Completion ____ / ____ / ____ *By X _____

*Initial if completed by nurse or physician's assistant