

**Town of Poughkeepsie
Recreation Department**

1 Overocker Road
Poughkeepsie, NY 12603

Phone (845) 485-3628
Fax (845) 485-3616

CAMP EMERGENCY/MEDICAL FORM

Confidential

Must be submitted 1 week prior to first day of camp

PLEASE PRINT

Last Name _____ First Name _____

Home Address _____

Home Phone _____ Date of Birth ____/____/____ Sex _____

Mother's Name _____ Father's Name _____

Business Phone _____ Business Phone _____

Cell Phone _____ Cell Phone _____

Emergency Contacts

1. Name _____ Daytime Phone _____ Cell Phone _____

2. Name _____ Daytime Phone _____ Cell Phone _____

Health Insurance Information

Carrier or Plan Name _____ Group # _____

Name of Insured _____ Relationship to Participant _____

Insurance ID # _____

In case of emergency, I understand that every effort will be made to contact me. In the event that I can not be reached, I give permission to the camp to act on my behalf in seeking and providing medical treatment for my child during the camp season. This includes medical care, transportation or treatment by camp staff, ambulance services, physician or hospital.

Signature of Parent/Guardian _____ Date _____

PLEASE COMPLETE REVERSE SIDE

Your child's safety and health are important to us. Please be honest in your responses so we can do everything within our abilities to insure your child has a safe and fun time in our summer program. If you have any questions concerning the information on this form, do not hesitate to ask us.

Name _____ Date _____

Health History
Confidential

Has your child ever had or do they now have:

	Now	Past	Explain
ADD/ADHD			
Asthma			
Cancer/Leukemia			
Convulsions/Seizures			
Diabetes			
Heart Trouble			
High Blood Pressure			
Joint or Bone Injury			
Surgery			
Other			

Allergies (to food, bees, insects or medication) _____

Medications

Taken in the last month _____

To be taken at camp _____

Any medications taken at camp:

- Will be self administered. We can not administer medication.
- Must be in their original pharmacy container.
- Must be accompanied by a note from a doctor.

Physical/Dietary Restrictions _____

Immunization Record (Show date of last immunization or booster)

	Date
DPT (Diphtheria, Tetnus, Pertussis)	
Hep B (Hepatitis B)	
HiB (Haemophilus Influenza)	
MMR (Measles, Mumps, Rubella)	
OPV (Polio)	
VZV (Varicella-Chicken Pox)	