KENWAL DAY CAMP
HEALTH INFORMATION- 2025
MUST BE COMPLETED AND RECEIVED TWO WEEKS PRIOR TO THE START CAMP

The information on this form is to assist us in planning appropriate care. Updates should be provided to the office as they occur.

Child's Name_____
Last First Middle

Birth date _____Age at camp _____Grade (as of 9/1/24)_____Gender at Birth_____

Home address _____Primary phone_____
Street address City Zip

Parent 1 Name _____Home address_____
(if different from above)

Business Phone _____Cell Phone_____

Parent 2 Name _____Home address_____
(if different from above)

Business Phone _____Cell Phone_____

Emergency Contact (Other than parents)_____Relationship_____Home/Work/Cell Phone_____

Allergies (List all known) Describe reaction and management of the reaction.

Medication allergies (list)

_____

_____

_____

Food allergies (list)_____

Other allergies (list) – include insect stings, hay fever, asthma, animal dander, etc._____

Restrictions (The following restrictions apply to this individual.)

Food: Red meat __Pork ___Dairy Products ___ Poultry ___Fish/Seafood ___Eggs __Other (describe)

Activity Restrictions: (e.g. What accommodations or limitations are necessary?)

*IN THE EVENT THAT I OR MY CONTACTS CANNOT BE REACHED IN AN **EMERGENCY**, I HEREBY GIVE MY PERMISSION TO KENWAL, THE LOCAL AMBULANCE/FIRE DEPARTMENT, MY FAMILY PHYSICIAN, ANY LOCAL PHYSICIAN, OR THE NEAREST HOSPITAL TO ADMINISTER EMERGENCY TREATMENT AND CARE. I FURTHER GIVE MY PERMISSION FOR ALL PERTINENT HEALTH INFORMATION TO BE DUPLICATED AND RELEASED TO THE APPROPRIATE PERSONNEL FOR EMERGENCY CARE.*

Signature/Parent/Legal Guardian Signature_____ Date_____

Child's name_____ Date of Birth_____

MEDICATIONS

Please list ALL medications (including over the counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the child's name, the prescribing physician (if a prescription drug,) the name of the medication, the dosage, route, and the frequency of administration. Ensure that medications are not expired. *A* ***Medication Administration Form*** (this form can be downloaded from our website) *MUST accompany all medications to be administered, routine or on an 'as needed' basis.*

This person **takes NO medications** on a routine basis.____ OR ___This person **takes medications** as follows:

Med #1 _____ Dosage _____Specific times taken each day

Reason for taking

Med #2 _____ Dosage _____Specific times taken each day

Reason for taking

GENERAL QUESTIONS (Explain "yes" answers below)

Has/does the participant?	Yes	No		Yes	No
1. Had any recent injury, illness, or infectious disease?			15. Ever been diagnosed with a heart murmur?		
2. Have a chronic or recurring illness/condition?			16. Ever had back problems?		
3. Ever been hospitalized?			17. Ever had problems with joints (e.g. knees, ankles)?		
4. Ever had surgery?			18. Have an orthodontic appliance being brought to camp?		
5. Have frequent headaches?			19. Have any skin problems (e.g. itching, rash, acne)?		
6. Ever had a head injury?			20. Have diabetes?		
7. Ever been knocked unconscious?			21. Have asthma?		
8. Wear glasses, contacts, or protective eyewear?			22. Had mononucleosis in the past 12 months?		
9. Ever had frequent ear infections?			23. Had problems with diarrhea/constipation?		
10. Ever passed out during or after exercise?			24. If female, have an abnormal menstrual history?		
11. Ever been dizzy during or after exercise?			25. Have a history of bed-wetting?		
12. Ever had seizures?			26. Ever had an eating disorder?		
13. Ever had chest pain during or after exercise?			27. Ever had emotional difficulties for which professional help was sought?		
14. Ever had high blood pressure?			28. Have Additional Health Concerns?		

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

_____

_____

_____

Name of family dentist/orthodontist:_____ _____

Address _____Phone _____

Is your Child COVID vaccinated?_____YES ____NO Which Brand?_____

FIRST SHOT DATE:_____ SECOND SHOT DATE:_____

SEE ATTACHED FOR ANNUAL MEDICAL FORMS – TO BE COMPLETED BY PHYSCIAN

The Department of Health regulations require a complete ANNUAL physical exam in order to attend & participate in camp. Please have your physician complete the attached form: annual physical exam & Immunizations/vaccinations.

Child's name _____ Date of birth_____

Either complete this form or PROVIDE PHYSICIAN'S ANNUAL PHYSICAL EXAM & IMMUNIZATION HEALTH HISTORY FORM

Which of the following has the participant had?

_____Measles _____Hepatitis A

_____Chicken Pox _____Hepatitis B

____German measles _____Hepatitis C

_____Mumps

Other:

Test:_____

*Height _____ *Weight_____

*Blood Pressure _____*Pulse

***REQUIRED BY PHYSCIAN**

I Have examined the above child and deem him/her fit to attend camp and participate in all activities.

Licensed Physician's Signature Print Name

_____ _____