COUNSELOR
HEALTH & REGISTRATIONFORM

CAMP WARWICK, P.O. BOX 349, WARWICK, NEW YORK 10990

COUNSELOR INFORMATION

LAST NAME ______________________________ **FIRST NAME** __________________________ **INITIAL** __________

PARENT/GUARDIAN INFORMATION

Last Name ____________________________________ First Name ____________________________ Initial ________

Address ____ Apt. # ________________

City _______________________________ State _______ Zip ________ Home Telephone _____________________

Spouse Name ____ Bus. Telephone ______________________

Cellphone ______________________

IN AN EMERGENCY, NOTIFY:

Emergency Contact ____ Telephone ___________________________

Relationship to Counselor _________________________________ Cellphone ______________________

CONSENT RELEASE

In signing this release, I certify that the information provided on this form is correct. In case of a medical emergency, I authorize the release of medical records and understand that every effort will be made to contact my emergency contact. Permission is hereby given to the physician selected by The Warwick Conference Center to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for myself, as named herein. I authorize the Camp Warwick Health Director to supervise the self-medication of prescription and over-the-counter medicines by myself at on-site camps and supervise the First Aid personnel of off-site camps in the distribution of medicines. I give permission for myself to be transported in The Warwick Conference Center vehicles or other designated vehicles to and from public transportation. I give permission for myself to be transported by public transportation as necessary for approved off-site camp activities. I authorize the use of photographs of myself in camp publicity.

COUNSELOR SIGNATURE REQUIRED:

____ ____________________________

COUNSELOR SIGNATURE **Date**

(COMPLETE HEALTH INFORMATION ON REVERSE SIDE)

COUNSELOR HEALTH INFORMATION

LAST NAME ________________________________ FIRST NAME ____________________________

Date of Birth ____/____/____ Age _______ ❑ Male ❑ Female

Date of Last Physical Exam ____/____/____

Physician/Clinic ____ Telephone ____________________

Street Address ____

City ____ State _________ Zip __________________

Health Insurance Co. __________________________________ Policy # ________________________

IMMUNIZATION RECORD

PLEASE PROVIDE AN OFFICAL IMMUNIZATION RECORD FROM YOUR DOCTOR'S OFFICE. THIS SHOULD INCLUDE A VERIFICATION OF A RECENT TB TEST*.
NOTE: **TB TEST MUST BE ADMINISTERED WITHIN TWO YEARS PRIOR TO THE START OF SUMMER CAMP.*

ALLERGIES

Asthma	❑ Yes	❑ No	Sulpha	❑ Yes	❑ No
Bee Sting	❑ Yes	❑ No	Suntan Lotion	❑ Yes	❑ No
Hay Fever	❑ Yes	❑ No	Poison Ivy/Oak/ Sumac	❑ Yes	❑ No
Penicillin	❑ Yes	❑ No			

Other: ____________________________________

FOOD ALLERGIES *(Please list)*

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MEDICATIONS

I give permission to the Camp Warwick Health Director to supervise and/or administer the following medications (check off):

_____ Antacids
_____ Aspirin
_____ Cold Medications
_____ Cough Syrup
_____ External Ointments
_____ Suntan Lotion
_____ Tylenol
_____ Benadryl
_____ Other over-the-counter medications (list):
____
____

MEDICAL INFORMATION

Are you in general good health and able to participate in all normal camp activities? ❑ Yes ❑ No

If no, please explain on a separate sheet of paper.

ADD	❑ Yes	❑ No	Heart Murmur	❑ Yes	❑ No
ADHD	❑ Yes	❑ No	Homesickness	❑ Yes	❑ No
Ear Infections	❑ Yes	❑ No	Hyperactive	❑ Yes	❑ No
Diabetic	❑ Yes	❑ No	Special Diet	❑ Yes	❑ No
Asthma	❑ Yes	❑ No	Seizure Disorders	❑ Yes	❑ No

List any of the following:
Chronic-recurring illness ______________________
Convulsive disorders ______________________
Recent illness/injury ______________________
Contagious diseases ______________________

Please submit statement of how you have been treated and with what medication.

Serious operations *(list date/type)*:______________________

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Please list ALL prescription medications you are currently taking. Include the dosage & instructions for use.

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Health Insurance Co. Phone #______________________________ *Please attach copy of insurance card (front & back)*

Prescription drug policy? ❑ Yes ❑ No *If yes, attach a photocopy of the card (front and back).*

The HEALTH DIRECTOR will supervise the self-medication of prescription and over-the-counter medicines by counselors at on-site camps and supervise the First Aid personnel while off-site in the distribution of medicine. The Health Director stocks most common medications such as Tylenol and cold remedies, so it is not necessary to bring them to camp. **ALL MEDICATIONS (PRESCRIPTION AND OVER-THE-COUNTER) MUST BE IN THE ORIGINAL CONTAINER, LABELED WITH THE COUNSELOR'S NAME AND WRITTEN INSTRUCTIONS SIGNED BY YOUR PHYSICIAN ATTACHED. ALL MEDICATIONS (PRESCRIPTION AND OVER-THE-COUNTER) MUST BE GIVEN TO THE HEALTH DIRECTOR**

Please keep a copy of this form for future reference.