



**Camp Duffield Registration Form (Please print)-page A**

**Date:** \_\_\_\_\_

**Name of Camper:** Last \_\_\_\_\_ First \_\_\_\_\_

Home Address: \_\_\_\_\_  
Street City State Zip

Home Phone# \_\_\_\_\_ Sex \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Grade Completed \_\_\_\_\_

Parents/Guardians: \_\_\_\_\_

Cell Phone# Mom: \_\_\_\_\_ Dad: \_\_\_\_\_

Parents email: \_\_\_\_\_ Camper email: \_\_\_\_\_

**Emergency Contact Information:** (If unable to reach a parent, someone who is available 24/7)

Contact name \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship \_\_\_\_\_

Contact name \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship \_\_\_\_\_

Campers Physician: \_\_\_\_\_ Phone \_\_\_\_\_

Physicians Address: \_\_\_\_\_  
Street City State Zip

**Chipmunks camp includes required parent stay and needs additional forms.**

| <b>Camp</b>  | <b>Date of Camp<br/>Circle one</b> | <b>Paid in Full<br/>by May 1st</b> | <b>Paid in Full<br/>by June 1st</b> | <b>Office Use Only<br/>(Date Received)</b> |
|--|------------------------------------|------------------------------------|-------------------------------------|--|
| Chipmunks<br>Grades 1 <sup>st</sup> - 2 <sup>nd</sup>  | July 10-13<br>July 17-20           | \$200                              | \$220                               |  |
| Foxes<br>Grades 3 <sup>rd</sup> -5 <sup>th</sup>       | July 10-16<br>July 17-23           | \$300                              | \$320                               |  |
| Raccoons<br>Grades 6 <sup>rd</sup> -8 <sup>th</sup>    | July 10-16<br>July 17-23           | \$300                              | \$320                               |  |
| Night Owls<br>Grades 9 <sup>th</sup> -12 <sup>th</sup> | July 24- July 30                   | \$290                              | \$320                               |  |

Camper's Tee-Shirt Size \_\_\_\_\_

**Fees and all forms must be completed and turned in by June 1<sup>st</sup>.**  
**Send to: Duffield Summer Camps, P.O. Box 55, Kenmore, NY, 14217**  
*Rev.150103*



**Camp Duffield Registration Form (Please print)-page B**

**Date:** \_\_\_\_\_

**Name of Camper:** \_\_\_\_\_

**Has camper traveled outside the country in the past 9 months?** \_\_\_\_\_

**When/Where** \_\_\_\_\_

- |     |  |                          |     |                          |    |
|-----|--|--------------------------|-----|--------------------------|----|
| 1.  | Has camper had a recent injury, illness or infectious disease?     | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 2.  | Are there any chronic or recurring illness/condition?              | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 3.  | Has camper been hospitalized or had any surgery?                   | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 4.  | Does camper have frequent headaches                                | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 5.  | Ever had a head injury or been knocked unconscious?                | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 6.  | Wear glasses or contacts   | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 7.  | Ever had frequent ear infections?                                  | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 8.  | Ever pass out or been dizzy during or after exercise?              | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 9.  | Ever had seizures or convulsions?                                  | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 10. | Ever had chest pains or diagnosed with a heart condition?          | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 11. | Any physical or mental disabilities? Explain below.                | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 12. | Ever had an eating disorder?                                       | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 13. | Ever had back or joint problems?                                   | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 14. | Have any skin problems?  | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 15. | Bringing an orthopedic device to camp?                             | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 16. | Have asthma?   | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 17. | Have diabetes?   | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 18. | Problems with sleepwalking or bed wetting?                         | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 19. | Had mononucleosis in past 12 months?                               | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 20. | Had problems with diarrhea/constipation?                           | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 21. | If female – abnormal menstrual history?                            | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 22. | Been involved in bullying or been bullied?                         | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 23. | Ever had a emotional problems for which professional help sought?  | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 24. | Hay fever or other allergies?                                      | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 25. | Bee sting reactions?   | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 26. | On a special diet, vegetarian, lactose free, gluten? Explain below | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 27. | Any other facts we need to know:                                   | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |

**Explain yes answers here:**

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**Authorizations: This health history is correct and complete to the best of my knowledge, and the person herein described has permission to engage in all camp activities . I hereby give permission to the medical personnel selected by the Camp Director to secure proper treatment and transportation, for my child named above if deemed necessary. I also give permission to share their medical information for this purpose. (This must be signed for camper to attend camp)**

\_\_\_\_\_  
Signature of parent or guardian

\_\_\_\_\_  
Date

**Fees and all forms must be completed and turned in by June 1<sup>st</sup> .  
Send to: Duffield Summer Camps, P.O. Box 55, Kenmore, NY, 14217**

Rev.150103



**Camp Duffield Registration Form (Please print)-page C**  
**Authorization from Parent/Guardian for person to**  
**Consent for treatment of minor patient**

I, \_\_\_\_\_ do hereby authorize Camp Duffield Staff to sign for any Medical Treatment deemed necessary for (print child name) \_\_\_\_\_, whose birth date is \_\_\_/\_\_\_/\_\_\_\_. This authorization is valid from (date) \_\_\_\_\_ through and including \_\_\_\_\_.

Today's Date \_\_\_\_\_

Parent/Guardian \_\_\_\_\_ **Print**

Parent/Guardian \_\_\_\_\_ **Signature**

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**The person herein described has appeared before me and is known by me or has presented Sufficient identification to prove, that he or she, is indeed, the above individual.**

**Notary Public Signature/Stamp/Date: "MUST BE COMPLETED"**

Health Insurance Company \_\_\_\_\_

Name of insured \_\_\_\_\_ Relationship to camper \_\_\_\_\_

Identification Number \_\_\_\_\_ Group No. \_\_\_\_\_

Place of Employment \_\_\_\_\_

Camper Physician: \_\_\_\_\_ Phone \_\_\_\_\_

**A photocopy of insurance card is required to attend camp.**

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**Physician's Report page 1 of 4**

**Camp Duffield Health History**

**Name of Camper:** \_\_\_\_\_ **DOB** \_\_\_/\_\_\_/\_\_\_

**Date of physical:** \_\_\_/\_\_\_/\_\_\_ (physical must be within past calendar year)

**Has camper been hospitalized within the past 3 years?** \_\_\_\_\_

**If yes explain details and dates:** \_\_\_\_\_

**Patient's:** HT \_\_\_\_\_ WT \_\_\_\_\_ P \_\_\_\_\_ BP \_\_\_\_\_ / \_\_\_\_\_ RR \_\_\_\_\_

**PHYSICAL EXAMINATION**

| SYSTEM             | WITHIN NORMAL | ABNORMAL | EXPLAIN REASON |
|--------------------|---------------|----------|----------------|
| HEAD, NECK         |               |          |                |
| EARS, NOSE, THROAT |               |          |                |
| LUNGS              |               |          |                |
| HEART              |               |          |                |
| ABDOMEN            |               |          |                |
| GENITALIA          |               |          |                |
| SPINE              |               |          |                |
| EXTREMITIES        |               |          |                |
| NEURO              |               |          |                |
| SKIN               |               |          |                |
| EYES               |               |          |                |

**MEDICATIONS**

Please list all medications (including over the counter or non prescription drugs) being taken. Bring enough medication to last the entire time at camp. Keep in original packaging/bottle that identifies the medication, the prescribing doctor, the dosage and frequency of administration.

| MEDICATION | DOSAGE | TIMES GIVEN | REASON | SPECIAL INSTRUCTIONS |
|------------|--------|-------------|--------|----------------------|
|            |        |             |        |                      |
|            |        |             |        |                      |
|            |        |             |        |                      |
|            |        |             |        |                      |
|            |        |             |        |                      |

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**Physician's Report page 2 of 4**

**Camp Duffield Health History**

**Name of Camper:** \_\_\_\_\_ **DOB** \_\_\_/\_\_\_/\_\_\_

**Immunization History:** Provide the **month and year for each immunization**. All immunizations must be current. Copies of immunization records from health-care providers are preferred.

**Immunization ( List or attach doctors records of immunizations )**

DTaP or TdaP \_\_\_\_\_  
 MMR \_\_\_\_\_  
 IVP \_\_\_\_\_  
 HIB \_\_\_\_\_  
 RV \_\_\_\_\_  
 Hepatitis A \_\_\_\_\_  
 Hepatitis B \_\_\_\_\_  
 Varicella \_\_\_\_\_  
 Meningococcal \_\_\_\_\_  
 Covid \_\_\_\_\_

**Allergy Information:** \_\_\_\_\_ Does not apply (no allergies please check)

| Allergy to: | Reaction: | Treatment: |
|-------------|-----------|------------|
| Seasonal:   |           |            |
| BEES        |           |            |
| Animals:    |           |            |
| Food:       |           |            |
| Food:       |           |            |
| Medication: |           |            |
| Medication: |           |            |
| Other       |           |            |
| Other       |           |            |

**Children required to carry epi pen, must bring the epi pen and physician's Rx. Peanut or Tree nut allergies please bring report from doctor as to allergy.**

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 Send to: Duffield Summer Camps, P.O. Box 55, Kenmore, NY, 14217**



Physician's Report page 3 of 4

**Camp Duffield Health History**

Name of Camper: \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

**OVER THE COUNTER MEDICATION FORM**  
**Your medical doctor must complete this form**

I hereby authorize that the following medications may be given to the above named camper at Camp Duffield after nursing assessment.

**Bactine** (topical) for minor wound care, first aid as needed

**Triple Antibiotic Ointment** (topical) for wound healing

**Tylenol** (oral) as directed on bottle

**Ibuprophen** (oral) as directed on bottle

**Cough Drops** for coughing, minor throat irritation as needed

**Antacid Tablet** (oral) for stomach discomfort

**Benzydrl** (oral or topical) for swelling, hives, and allergic reaction as directed on bottle

**Calamine Lotion or Cortaid** (topical) for insect bites/bee stings

**Visine/ Murine Plus Eye Drops** (topical in eye) for minor eye irritation

**Other (please describe)** \_\_\_\_\_  
\_\_\_\_\_

|                           |                                 |
|---------------------------|---------------------------------|
| <b>PHYSICIAN CONSENT</b>  |                                 |
| Physician Signature _____ | Date _____                      |
| Printed Name _____        | License Number _____            |
| Address _____             | Phone _____                     |
| City _____                | State _____ Zip _____ Fax _____ |

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Physician's Report page 4 of 4

Camp Duffield Health Medication Forms

Name of Camper: \_\_\_\_\_ DOB \_\_\_/\_\_\_/\_\_\_

**For Prescription Medications:**

Any use of prescription drugs must be ordered by the Camper's Physician and brought in original container. This form must be completed **for each prescription** to be administered and signed by the Camper's Physician.

**For Over-the Counter Medications:**

Any additional over-the-counter medication not listed on page 3 must have specific directions and be in the original container. This form needs to be completed **for these over-the-counter medication** the Camper uses.

\_\_\_\_\_  
**Please give the following medications to the above named Camper:**

Name of Prescription Medication: \_\_\_\_\_

Dosage of Drug: \_\_\_\_\_

Times to be administered: \_\_\_\_\_

Length of time drug is to be given: \_\_\_\_\_

Special instructions: \_\_\_\_\_

**PHYSICIAN CONSENT**

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

Printed Name \_\_\_\_\_ License Number \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Fax \_\_\_\_\_

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