



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.

Camp	Date of Camp Circle one	Paid in Full by May 1st	Paid in Full by June 1st	Office Use Only (Date Received)
Chipmunks Grades 1 st - 2 nd	July 9 - 12 July 16 - 19	\$200	\$220	
Science Grades 3 rd -5 th	July 9 - 15	\$300	\$320	
Music Grades 6 rd -8 th	July 16 - 22	\$300	\$320	
Night Owls Grades 8 rd -12 th	July 23- July 29	\$300	\$320	
Impact 716 Grades 3 rd – 12 ^t	July 30 – Aug 5	\$300	\$320	

Camper's Tee-Shirt Size _____

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



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:

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

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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**

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 _____
- IIVP _____
- 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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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

Benzydyl (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) _____

PHYSICIAN CONSENT

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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