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 1st - 2nd	July 12-15 July 19-22	$175	$220	
Foxes Grades 3rd -5th	July 12-18 July 19-25	$290	$320	
Raccoons Grades 6rd -8th	July 12-18 July 19-25	$290	$320	
Night Owls Grades 9th-12th	July 26- Aug 1	$290	$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

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

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 orTree nut allergies please bring report from doctor as to allergy.

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

Benydryl (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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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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