



Hyde Park Recreation  
Camper Information Packet

**Medical History Information**

Please fill out one medical history form for **EACH** child.  
Additional sheets are on our website or in our office.

**Camper Information**

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Gender: M / F Age: \_\_\_\_\_ Grade Entering in Fall: \_\_\_\_\_

**Emergency Contact Information**

1. Name/Relation: \_\_\_\_\_ Phone: \_\_\_\_\_  
2. Name/Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

**Physician Information**

Physician: \_\_\_\_\_ Office Phone #: \_\_\_\_\_  
Medical/Hospital Insurance Carrier: \_\_\_\_\_ Policy/Group #: \_\_\_\_\_  
Preferred Hospital: \_\_\_\_\_

**Camper Health History**

Do you have or are you subject to any of the following:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Allergies                | <input type="checkbox"/> Dietary Restrictions | <input type="checkbox"/> Mental Condition      |
| <input type="checkbox"/> Allergy or Drug Reaction | <input type="checkbox"/> Ear Infections       | <input type="checkbox"/> Poison Ivy Sensitive  |
| <input type="checkbox"/> Asthma                   | <input type="checkbox"/> Fainting Spell       | <input type="checkbox"/> Seizures              |
| <input type="checkbox"/> Bee Sting Reaction       | <input type="checkbox"/> Hay Fever            | <input type="checkbox"/> Sports Restriction    |
| <input type="checkbox"/> Bleeding Disorder        | <input type="checkbox"/> Heart Disease/Defect | <input type="checkbox"/> Swimming Restrictions |
| <input type="checkbox"/> Diabetes                 |   | <input type="checkbox"/> Other                 |

Please explain any of the above: \_\_\_\_\_

★ If female: Started Menstruation? \_\_\_\_\_ If no, has been told about it? \_\_\_\_\_

If you have had any of the following illnesses, please give the approximate dates of infection:

_____ Measles	_____ Mumps	_____ Chicken Pox
_____ German Measles	_____ Mononucleosis	_____ Diphtheria



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**Medical History Information (Cont)**

Any operations or serious injuries: (Include Dates) \_\_\_\_\_

Any disability or chronic illness: \_\_\_\_\_

Any restrictions for medical reasons: \_\_\_\_\_

Please list all medication your camper takes, including over the counter medications, with specific dose:

\_\_\_\_\_

***\*\*For any medication that needs to be dispensed during camp hours,\*\****

***\*\*please attach a doctor's note authorizing administration by camp personnel.\*\****

**Please attach the most recent immunization record for this individual to this form.**

**This health history and information is correct as far as I know. The person herein described has permission to engage in all camp activities, except as noted. In the event I cannot be reached in an emergency, I hereby give permission to medical personnel selected by the Camp Director to order x-rays, routine tests, to hospitalize, secure proper treatment for and to order injections or anesthesia and/or surgery for my child as named above.**

**I, (Parent/Guardian) \_\_\_\_\_, do hereby recognize the risks of illness and injury inherent during the time of the use of The Town of Hyde Park recreational facilities. Therefore, I do hereby, for myself, my heirs, executors and administrators, waive and release any and all rights and claims for damages I and/or my guests and participants may have against the Hyde Park Recreation Department, their agents, representatives, successors and assigns for any/all injuries suffered by the undersigned and his/her guests and participants during this event.**

Parent/Guardian Name (Printed)

Parent/Guardian Signature

\_\_\_\_\_

\_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_