MANDATORY HEALTH PACKET

To parent/guardian: Please follow the instructions below. These forms are required—no child will be allowed to participate in camp without complete forms. While the information on these forms is not part of the acceptance process, it may be valuable to emergency personnel, if needed. It also assists staff in identifying appropriate care for your child during camp. Changes to this form must be submitted in writing.

1. **Complete pages 1-3** (One form per child)
2. **Provide page 4 to child's health care provider**
3. **Submit all forms to TNC <u>7 days in advance</u> of first day of camp**
   (mail, drop-off, fax or scan and e-mail: ddavidson@tenaflynaturecenter.org)

EMERGENCY CONTACTS & HEALTH RECORD: TO BE COMPLETED BY PARENT/GUARDIAN

1. Emergency Contact Information

Camper-First Name ________________________________ Last Name ___________________________________

Birth date___________________________ Grade Entering_____________ Age____________ Male ❑ Female ❑

Address ____
Street City State Zip

A. Parent/Guardian____

Address ____ Cell # _______________________________
(If different from camper)

Email ____ Home # _______________________________

B. Parent/Guardian or Emergency contact ____

Address____ Cell # _______________________________
(If different from camper)

Relationship ______________________________________ Home # _______________________________

C. Alternate Emergency contact____

Address____ Cell # _______________________________

Relationship ______________________________________ Home # _______________________________

2. Insurance and Doctor Information ❑Yes ❑No Is camper is covered by family medical/hospital insurance?
Include a copy of your insurance card; copy both sides of the card so information is readable.

Insurance Company________________________________ Policy Number _________________________________

Subscriber _________________________________Insurance Company Phone Number______________________

Camper primary physician____ Phone____________________________

Camper dentist ____ Phone____________________________

Camper orthodontist____ Phone____________________________

3. Allergies ❑None ❑Food ❑Medicine ❑Environment (insect stings, hay fever, etc.) ❑Other

List all specific known allergies Describe reaction and management of the reaction.

______________________________ ____

______________________________ ____

4. Diet Restrictions❑None ❑Vegetarian ❑Kosher ❑No Peanuts ❑No Wheat ❑No Dairy ❑Other

Comments: ____

Name of child: ____

HEALTH RECORD CONTINUED: TO BE COMPLETED BY PARENT/GUARDIAN

5. Activity Restrictions or Special Needs

Please describe how your child's particular challenges (medical, behavioral, emotional, learning) present themselves in a group setting and if there are helpful accommodations that have aided your child in group settings before? Please describe. Include any health information that is important or may affect their ability to fully participate in the program. Attach additional information as needed

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6. Medications

Please list all medications currently taken. Medications are any substance taken to maintain and/or improve their health. This includes vitamins, natural remedies, over-the counter/non-prescription drugs. TNC does not stock any medication. Attach additional information as needed.

❑ None. This camper does not take any daily medication & will not take any daily medication while attending camp.

A. Medication _______________________Dosage__________ Specific times taken each day ______________

Reason for taking ____

Must be taken at camp?* ❑Yes ❑No To be stored at TNC during camp week?* ❑Yes ❑No

B. Medication _______________________Dosage__________ Specific times taken each day ______________

Reason for taking ____

Must be taken at camp?* ❑Yes ❑No To be stored at TNC during camp week?* ❑Yes ❑No

* Please provide enough of each medication to last the entire week of camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), name of the medication, dosage, and frequency of administration. Medications may only be stored at TNC during the week the child is attending camp.

7. General Health History (Explain "yes" answers below)

Has/does the participant:	Yes	No
1. Ever been hospitalized	❑	❑
2. Ever had surgery	❑	❑
3. Have any limitations to physical activities	❑	❑
4. Have chronic/recurrent illness/condition	❑	❑
5. Had a recent illness/infectious disease	❑	❑
6. Had a recent injury	❑	❑
7. Had asthma/wheezing/shortness of breath	❑	❑
8. Have diabetes	❑	❑
9. Had seizures	❑	❑
10. Had headaches	❑	❑
11. Wear glasses, contacts or protective eye wear	❑	❑
12. Have an orthodontic appliance at camp	❑	❑
13. Have any special equipment needs	❑	❑
14. Ever been knocked unconscious	❑	❑
15. Had fainting or dizziness	❑	❑
16. Ever had a head injury	❑	❑
17. Had problems with falling asleep/sleepwalking	❑	❑
18. Passed out/had chest pain during/after exercise	❑	❑
19. If female, have problems with periods/menstruation	❑	❑
20. Had mononucleosis in the past 12 months.	❑	❑
21. Ever had back/joint problems	❑	❑
22. Have a history of bed-wetting	❑	❑
23. Had problems with diarrhea/constipation	❑	❑
24. Have any skin problems	❑	❑
25. Ever had high blood pressure	❑	❑
26. Ever been diagnosed with a heart murmur	❑	❑
27. Traveled outside the country in the past 9 months	❑	❑
28. Been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)	❑	❑
29. During the past 12 months, seen a professional to address mental/emotional health concerns	❑	❑
30. Ever been treated for emotional or behavioral difficulties or an eating disorder	❑	❑
31. Had a significant life event that continues to affect the camper's life (History of abuse, family change or death, adoption, survived a disaster, others)	❑	❑

Please explain "Yes" answers in the space below, noting the number of each question. For travel outside the country, please name countries visited and dates of travel. Staff may contact you for additional information.

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Immunization History: Please note, if your health care provider will not be including a complete immunization form (page 4) the Health Department requires a written statement signed by the parent or guardian explaining how the administration of immunizing agents conflicts with the camper's exercise of bona fide religious tenets or practices. General philosophical or moral objection to immunization shall not be sufficient for an exemption on religious grounds.

Name of child: ____

RELEASES & PERMISSIONS: TO BE COMPLETED BY PARENT/GUARDIAN

Please fill out and <u>initial each section</u> regardless of your response. Sign and date the box below.

______ Alternate Pick-up Release (mandatory if anyone other than you will be picking up your child)

❑ No one but the signatory of this form may pick up my child.

❑ The following people are authorized to pick up my child from camp. Please specify days/dates if possible.

Name: ____ Relationship: _____________________________

Name: ____ Relationship: _____________________________

Name: ____ Relationship: _____________________________

Dates for alternate pick-up or other comments: ____

______ Carpool Information Release

❑ I wish to receive, and be included in, the carpooling list that will be sent to other camp participants and therefore give permission to the staff of the Tenafly Nature Center to release my name, address and phone number to other program participants for the purpose of carpooling.

❑ I do **not** wish to receive, or be included in, the carpooling list that will be sent to other camp participants.

______ Photo Release

❑ I hereby grant Tenafly Nature Center Association permission to use my child's likeness in photograph(s)/video in any and all of its publications and in any and all other media, whether now known or hereafter existing, controlled by Tenafly Nature Center Association, in perpetuity, and for other use by the Nature Center. I will make no monetary or other claim (whether for breach of privacy or otherwise) against Tenafly Nature Center Association for the use of the photograph(s)/video for educational or marketing purposes.

❑ I do **not** give TNC permission to publish photographs of me or my child taken during TNC programs.

______ Sunscreen Permission (participant must provide their own sunscreen)

❑ I give Tenafly Nature Center's staff permission to apply sunscreen as needed.

❑ I do **not** give Tenafly Nature Center's staff permission to apply sunscreen as needed.

______ Campfire Volunteer Request Form (1st-8th grade camp weeks only)

Parents/guardians are invited to attend the campfire for 1st-8th grade camp weeks.

❑ I would like to volunteer to help during the campfire.

❑ I would like to donate a food or beverage item for the campfire.

Parent/Guardian Authorization:

I, the undersigned, hereby give permission for my child to participate in all activities (unless otherwise specified) and assume all risks and hazards incidental to the program. I also hold harmless Tenafly Nature Center, its personnel, appointed assistants, trustees & the Borough of Tenafly.

This health history and any attached forms are correct and complete as far as I know, and accurately reflects the health status of the person herein described. This person has permission to engage in all camp activities except as noted by me and/or an examining physician. I also understand and agree to abide by any restrictions placed on my child's participation in camp activities.

I understand that it is the policy of Tenafly Nature Center and its personnel not to physically administer any medication to participants. Properly labeled medications may be stored at TNC in the designated refrigerator in the First Aid area. I understand that Tenafly Nature Center personnel will retrieve medications, aid my children in receiving necessary medications, and document medication usage in a log book; this child must have the ability to self-administer all medications when necessary.

I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status. I agree to the release of any records necessary for insurance purposes.

I hereby give permission to Tenafly Nature Center staff to provide routine health care and seek emergency medical treatment including ordering x-rays or routine tests. I give permission to the staff to arrange necessary related transportation for my child. If I cannot be reached in an emergency, I give my permission to the physician selected by the Tenafly Nature Center staff to hospitalize, secure and administer proper treatment, and order injection, anesthesia, or surgery for the person named above.

Signature of parent/guardian ____

Printed Name ____ **Date** _______________

MANDATORY HEALTH PACKET: UNIVERSAL CHILD HEALTH RECORD

UNIVERSAL CHILD HEALTH RECORD

Endorsed by: American Academy of Pediatrics, New Jersey Chapter, New Jersey Academy of Family Physicians, & New Jersey Department of Health and Senior Services

SECTION I - TO BE COMPLETED BY PARENT(S)

Child's Name *(Last)*	*(First)*	Gender ☐ Male ☐ Female	Date of Birth / /

Does Child Have Health Insurance? ☐Yes ☐No	If Yes, Name of Child's Health Insurance Carrier

Parent/Guardian Name	Home Telephone Number	Work Telephone/Cell Phone Number
Parent/Guardian Name	Home Telephone Number	Work Telephone/Cell Phone Number

I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.

Signature/Date	This form may be released to WIC. ☐Yes ☐No

Date of Physical Examination:	Results of physical examination normal? ☐Yes ☐No

Abnormalities Noted:	Weight *(must be taken within 30 days for WIC)*	
	Height *(must be taken within 30 days for WIC)*	
	Blood Pressure *(if ≥3 Years)*	

IMMUNIZATIONS	☐ Immunization Record Attached ☐ Date Next Immunization Due: ______

MEDICAL CONDITIONS

Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:	☐ None ☐ Special Care Plan Attached	Comments
Medications/Treatments • List medications/treatments:	☐ None ☐ Special Care Plan Attached	Comments
Limitations to Physical Activity • List limitations/special considerations:	☐ None ☐ Special Care Plan Attached	Comments
Special Equipment Needs • List items necessary for daily activities	☐ None ☐ Special Care Plan Attached	Comments
Allergies/Sensitivities • List allergies:	☐ None ☐ Special Care Plan Attached	Comments
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:	☐ None ☐ Special Care Plan Attached	Comments
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:	☐ None ☐ Special Care Plan Attached	Comments
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:	☐ None ☐ Special Care Plan Attached	Comments

PREVENTIVE HEALTH SCREENINGS

Type Screening	Date Performed	Record Value	Type Screening	Date Performed	Note if Abnormal
Hgb/Hct			Hearing		
Lead: ☐ Capillary ☐ Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		

☐ ***I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports, unless noted above.***

Name of Health Care Provider (Print)	Health Care Provider Stamp:
Signature/Date	