Camp Bournedale

110 Valley Road
Plymouth, MA 02360
(508)888-2634

OUTDOOR EDUCATION HEALTH FORM

Name: _____ D.O.B.: _____Age: _____M/F:_____ Grade: _____
Home address: _____ School name: _____

Parent/Guardian with LEGAL custody to be contacted In Case of Emergency

Name: _____ Relationship to Student: _____
Preferred Phone #'s: 1. _____ 2. _____ Email: _____

Second Parent/Guardian or other Emergency Contact

Name: _____ Relationship to Student: _____
Preferred Phone #'s: 1. _____ 2. _____ Email: _____

Additional Emergency Contact in the event parent/guardian cannot be reached

Name: _____ Relationship to Student: _____
Preferred Phone #'s: 1. _____ 2. _____ Email: _____

Family Physician: _____ Address: _____

Does your child have any dietary restrictions or food allergies? (Please describe below what the allergy and/or restriction is as well as the reaction seen).

_____
_____.

Does your child have any allergies to medicines, bee stings or environmental? Please describe:

_____
_____.

Will your child be under medical treatment for ANY condition(s) during this program? NO _____ YES_____

If yes, please explain: _____
_____.

Does your child have any chronic illnesses? NO _____ YES _____ If yes, please explain: _____
_____.

Should there be any restrictions on your child's activities? NO _____ YES _____ Please explain: _____
_____
_____.

Please note any additional information or suggestions regarding your child which may be helpful:

Emotional Stability: _____
Maturity: _____
Any personal problems: _____
Any behavioral problems: _____
Any learning problems: _____
Has your child had Chicken Pox? NO _____ YES _____
Has your child had the Varicella Vaccine (Chicken Pox Vaccine)? NO _____ YES _____
Has your child had the Covid Vaccine? NO _____ YES _____ Dates of Vaccine (s): _____
Date of last Tetanus Vaccine: _____

****Please attach your child's most recent IMMUNIZATION and history/physical form SIGNED (can be electronically signed) by your child's physician** (This must be attached for students to be allowed onto campus).**

****Please list any medications your child will need at camp. Prescribed medication must be in original container bearing a pharmacy label that shows the prescription number, date filled, physician name, medication name and directions for use. ****

****Non-prescriptions must be in their original containers with directions for use. All medication whether prescription or non-prescription must have physician's signature to be administered. ****

Medications	Amount	Time Given
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PHYSICIAN'S SIGNATURE: _____ **Date:** _____

I understand every effort will be made to contact me; however, IN CASE OF EMERGENCY, I hereby give permission to the physician selected by the camps personnel to hospitalize, secure proper treatment for an order of injection, anesthesia or surgery for my child. I give permission to the camps nurse and staff members to supervise my child while taking the above medication(s) and to administer first aid if needed. I also give permission to the camp nursing staff to provide basic care in case of sudden illness (I.E.: sore throat, fever, cold symptoms) and dispense over the counter medications as needed.

The following is a list of stocked non-prescription medications. Please check those your child could have on an AS NEEDED BASIS to manage illness and injury.

Acetaminophen (Tylenol) _____
Ibuprofen _____
Benadryl _____
Cough Drops _____
Sore Throat Drops _____

Calamine Lotion _____
Antibiotic Cream _____
Aloe _____
Tums _____

Parent/Guardian Signature: _____ **Date:** _____

_____
Insurance Company

_____
Policy/Group Number

_____
Name of Insured

Should you have any questions please call our Camp Nurse at (617)680-5168