

Springfield College Camp Massasoit
263 Alden Street
Springfield, MA 01109-3797
2019 Emergency Contact and Health Record

Child's Name: _____ **Gender:** _____

Last First M.I.

DOB: _____ / _____ / _____ Age in camp: _____

Parents/Guardian:

Name: _____ Relation to Child: _____

Last First

Address: _____

Street Town/City State Zip Code

Phone (Home): (____) _____ - _____ Phone (Work): (____) _____ - _____ Phone (Cell): (____) _____ - _____

Name: _____ Relation to Child: _____

Last First

Address (if different from above): _____

Street Town/City State Zip Code

Phone (Home): (____) _____ - _____ Phone (Work): (____) _____ - _____ Phone (Cell): (____) _____ - _____

One Additional Emergency Contact:

Name: _____ Relation to Child: _____

Last First

Address: _____

Street Town/City State Zip Code

Phone (Home): (____) _____ - _____ Phone (Work): (____) _____ - _____ Phone (Cell): (____) _____ - _____

Health History: Provide dates and other information requested or indicate N/A (not applicable) if appropriate.

Ear Infections _____ Chicken Pox _____ Measles _____

Convulsions _____ German measles _____ Diabetes _____

Mumps _____ Bleeding disorder _____ Tuberculosis _____

Allergies: _____

Operations/Serious Injuries: _____

Disability or chronic or recurring illness: _____

Current medications: _____

Family Medical Insurance Carrier: _____ Policy # _____

Name of Dentist/Orthodontist: _____ Phone # _____

Name of Family Physician: _____ Phone # _____

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

IMPORTANT: Camp Massasoit must be notified immediately if a camper has been exposed to a communicable disease during or within three weeks prior to attendance.

Immunizations: This section must be completed by a licensed health care provider or attach a copy of immunization documentation or alternative proof of immunity.

REQUIRED IMMUNIZATIONS (Campers under 18 years of age)	DATE (Month/Day/Year)
MMR (1 st dose age 12 months or older)	
Measles #2 or MMR #2 (Given at age 4 – 6 years and at least 1 month after 1 st dose)	
Polio (3 doses of OPV or IPV or 4 doses of mix IPV and OPV)	#1 #2 #3 #4
Diphtheria and Tetanus Toxoids and Pertussis (4 doses of DTaP/DTP/DT/Td. Booster dose of Td required if more than 10 years since last dose)	#1 #2 #3 #4 Booster (if applicable)
Hepatitis B (3 doses if born on or after January 1, 1992)	#1 #2 #3

LEAD SCREENING: _____

Effective 3/01/90 Massachusetts State Law requires all children, regardless of risk, shall be screened at least once between the ages of 9-12 months and annually until the age of 48 months. Children who are determined to be at high risk for lead exposure must be screened every 6 months and 3 years and yearly from 3 years to 6 years. Children must present evidence of having been previously screened as a condition for entry to kindergarten.

Physical Examination By a Physician: This section must be completed by a physician or attach a copy of a physical examination conducted by a physician during the preceding 24 months.

DATE OF MOST RECENT PHYSICAL EXAM: _____

Height:	Eyes:	Abdomen:
Weight:	Vision:	Genitalia, Hernia:
BP:	Ears, Nose, Throat:	Musculoskeletal:
HCT or Hgb:	Heart:	Neurological Exam:
Urinalysis:	Lungs:	Skin:

Recommendation for Camp Participation:

- Is person capable of participating in active camp program(s)? Yes No
- Please explain any restriction(s) _____
- Is person currently taking medication(s)? _____
- List any medications to be administered by Camp Health Supervisor _____

Signature of Health Care Provider: _____ Date: _____

Printed Name of Health Care Provider: _____ Phone: _____

Office Address: _____