Springfield College Camp Massasoit/East Campus
263 Alden Street
Springfield, MA 01109-3797

2025 Emergency Contact and Health Record

Child's Name (First & Last):____ DOB:______/_____/______

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): (_____) _____-_______

PLEASE COMPLETE- REQUIRED

I, ______________________ give permission for my child to use hand sanitizer, that has at least 60% alcohol, provided by East Campus/Camp Massasoit in the event my child isn't near an adequate handwashing facility.

Please Circle YES NO

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:____

Any current mental, emotional, social health, developmental, or psychological conditions requiring medication, treatment or special considerations while at camp:____

____

Current medications:____

Family Medical Insurance Carrier:____ Policy # ____________________

Name of Family Physician: ____ Phone #____________________

Signature of Parent/Guardian: ____ Date: ______________

IMPORTANT: East Campus/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 (1st dose age 12 months or older)	
Measles #2 or MMR #2 (Given at age 4 – 6 years and at least 1 month after 1st dose)	
Polio (3 doses of OPV or IPV or 4 doses of mix IPV and OPV)	**#1** **#2** **#3** **#4**
Diptheria 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**
OPTIONAL IMMUNIZATIONS (Campers under 18 years of age)	**DATE (Month/Day/Year)**
COVID- 19	**#1** **#2** **Booster** (if applicable)

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 ______________________

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Signature of Health Care Provider: ______________________________________Date: ____________

Printed Name of Health Care Provider: ___________________________________Phone: ___________

Office Address: ____