HAMILTON - WENHAM
RECREATION DEPARTMENT

EMERGENCY INFORMATION & HEALTH FORM

SPORTS CAMPS

Name of program. ______________________

Program Participant Information

Last Name ______________________ **First Name** ______________________

Date of Birth ____________ ☐ Male ☐ Female Child's Age ______________

Primary Guardian's Information

Name ______________________

Address ______________________

City __________ State ____ Zip Code ________

Home Phone # ______________________

Cell Phone # ______________________

Work Phone # ______________________

email ______________________

Secondary Guardian's Information

Name ______________________

Address ______________________

City __________ State ____ Zip Code ________

Home Phone # ______________________

Cell Phone # ______________________

Work Phone # ______________________

email ______________________

Emergency Contact Information

Name of Contact ______________________ Relationship ______________

Phone # ______________________

Health Care Information

Physician's Name ______________________ Phone # ______________

Insurance Carrier ______________________ Policy # ______________

Does the participant have any allergies?

Does the participant have any special needs or concerns that the staff need to be aware of?

HEALTH HISTORY

Have you had? (circle choice)	NO	Yes	Have you had? (circle choice)	NO	Yes
Recurrent Headache			Asthma		
Eye Problem			Epilepsy/Seizures		
Ear Problem			Dizziness/Fainting with exercise		
Nose Problem			Head Injury/Concussion		
Throat Problem			Bone/Joint Injuries		
Thyroid Disorder			Stomach/Intestinal Problems		
Heart Murmur/Heart Disease			Diabetes		
Heart Palpitations			Eating Disorder		
High/Low Blood Pressure			ADD/ADHD		
Anemia/Sickle Cell			Chicken Pox/Immunization		
Bleeding Disorders: Hemophilia/Other			Mononucleosis		
Hepatitis			Alcohol Abuse		
Kidney/Bladder Disorders			Drug Abuse		
Pneumonia/Bronchitis			Sexual Assault/Violence		
Tuberculosis			Emotional Problems-Specify below:		
Seasonal Allergies/Hay Fever					
Surgeries:					
Hospitalizations:					

Allergies:
Medication Allergies:
Medication currently taking:

Any other disease, illness, past surgeries, permanent disabilities, or explanations of any marked concerns from the list above?

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Are you currently being treated by a health care professional? If yes, explain____________________

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MEDICAL CARE:

The director has my permission to arrange and provide medical in the event the camper is injured. If my child is taking any form of medication, I give the camp trainer permission to administer this medication. I agree that medication will be kept in original bottles and / or containers.

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Parent / Guardian Signature

PLEASE ATTACH THE FOLLOWING

An updated copy of the participants immunizations with a physicans signature and proof of a physical within the last 2 years.

Signature of Guardian ____________________________ Date ____________