High Braes Refuge

196 Waterbury Road, Redfield, NY 13437

2024 Camper Confidential Medical Health Form

Phone: (315) 599-7362 Fax: (315) 599-4005

email: contactus@highbraes.com

To be completed by parent or guardian

Completion of both sides of this form is required for camp attendance

Personal Information

Camper First Name:	Last Name:	Initial:	Male ___ Female___
Age at time of Camp:	DOB:	Name of Parent/Guardian:	
Home Phone:	Work Phone:	Cell Phone:	
St. Address:	City:	State:	Zip:
(List two other people to be notified if you cannot be reached in case of an emergency. Please include name, address and phone number) 1.			
2.			

Medical History

Health History	Yes	No
Convulsions		
Diabetes		
Bleeding/Clotting Disorder		
Frequent Ear Infections		
Heart Defect/Disease		
Hypertention		

Allergies	Yes	No
Hay Fever		
Asthma		
Poison Ivy		
Insect Bites		
Penicillin		
Other Drugs (Specify)		

Diseases	Yes	No	Indicate Month and Year Below
Chicken Pox			
Measles			
Rubella			
Mumps			
Mononucleosis			
Other (Specify)			

(Use this space below to give additional information on those items checked "yes" above)

____

____

____

Operations or Serious Injuries: ______________________________________ Date: ___________

Chronic or recurring illness: ____

Is there any special information regarding this person's health, which the camp staff should know to help us in the caring for your child: ____

____

New York State law requires dates of the following immunizations:

Diphteria, haemophilus influenza type b, hepatitis b, measles, mumps, poliomyelitis, rubella, tetanus and varicella (chicken pox).

*** **Only an official immunization record can be excepted for entrance into camp** ***

Height _________ Weight _________

Camper Medications:

Current Medications: ____
(All medications must be brought to camp in the original container with physician instructions)
(Please attach any physicians' orders)

Dietary Restrictions:____

Any specific activities to be limited by physician's advice: ____________________________________
____

Medical Insurance Information: This person is covered by medical insurance: Yes ☐ No ☐

Name of Family Physician: ________________________________ Phone: _________________

Name of Person carrying insurance: _________________________ Carrier Birth Date: __________

Name of Insurance Company: ________________________________

ID#: ______________________ Group Number: _____________________________

If it becomes necessary to take your child to an emergency room for treatment, which area hospital would you prefer:

____

Note: Please inform the camp nurse of any health changes since completion of this form upon arrival at camp. Health changes such as medication, diet, and exposure to any communicable diseases should be reported.

Medical Permission

The above information is correct to the best of my knowledge. There are no physical ailments which would prevent the above named person from taking part in all the camp activities, including athletics and sports, at High Braes Refuge with the exception of those noted above.

Emergency Authorization: I hereby give permission to High Braes Refuge medical personnel to provide lifesaving emergency care for my child in the event such treatment is needed. I also give permission to order for x-rays, routine tests and treatment for my child in the event I/my alternate contact cannot be reached in an emergency. I hereby give permission to the physician selected by the camp to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for my child named above should it become necessary.

Dates this camper will be at camp: ___________________________________

Parent/Guardian Signature: ____ Date: _________________