STONEWALL FARM
Health History/Emergency Care Form

Complete and return to Stonewall Farm by June 1st via E-mail at abright@stonewallfarm.org or mail to: Attention Summer Camp, Stonewall Farm, 242 Chesterfield Rd. Keene, NH 03431.

Any changes to this form should be provided to the Camp Director upon participant's arrival at camp. Please provide complete information so Camp Staff are aware of your needs.

Dates Attending Camp:_____

Camper Information:

Camper Name _____ Birth Date ___/___/___ Gender __ Age at camp ___
Home address _____
City, State, Zip _____ Home Phone: ( ) _____
School _____ Entering Grade _____

Parent/Guardian Information

1. Parent/Guardian Name _____ Address_____
   Home Phone: ( )_____ Evening Phone ( ) _____ Cell ( )_____
2. Second Parent/Guardian _____ Address _____
   Home Phone: ( )_____ Evening Phone ( )_____ Cell ( )_____

Emergency Contacts (please provide *two names* other than parents)

In the event I am unable to be contacted, please contact the persons listed below:

Name	Phone (day, cell & evening)	Relation to Camper
1._____		
2._____		

Insurance & Doctor's Information

Is the camper covered by family medical/hospital insurance? __ Yes __ No
If so, indicate carrier or plan name _____ Group/Policy # _____
Family Doctor Name _____
Doctor's Address _____
Dr.'s Business Phone ( )_____ Dr.'s Emergency Phone ( )_____

Restrictions

Dietary Restrictions: _____
Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary)_____
_____

Important - This section must be completed for attendance*

Parent Authorization Statement

The health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted. In the event that I am unable to be reached in an emergency, I hereby authorize the Stonewall Farm staff and/or medical personnel selected by Stonewall Farm to take

emergency measures as needed. I understand this may include arranging necessary related transportation, x-rays, routine tests, treatment, and release of records necessary for insurance purposes. The selected physician has my permission to secure and administer treatment, including hospitalization, for my child. This completed form may be photocopied.

Signature of Parent or Guardian

_____Date_____

*If for religious reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance.

Medications Please list all medications (including over the counter or non-prescription drugs) taken routinely. Keep original packaging container that identifies the prescribing physician (if prescription drug), the name of the medication, the dosage and frequency of administration. **Both prescription and non-prescription medications must be provided in their original containers or they will not be administered.** All medication is distributed by staff members.

Is your child currently taking any medications: ___No ___ Yes (Please list. **Use additional sheet if necessary.**)

Name_____Name_____

Dosage_____Dosage_____

Time(s) to be administered_____Time(s) to be administered_____

Date(s) to be administered_____Date(s) to be administered_____

Reason for taking_____Reason for taking_____

Will your child be taking any medication while participating in our programs? __ No __ Yes

Medical History

Asthma: __ No __ Yes (explain) _____

Date of last asthma attack_____ Does your child carry an inhaler? __ No __ Yes

Does your child carry an epi-pen? __ No __ Yes (explain)_____

Heart/Respiratory Problems? __ No __ Yes (explain)_____

Epileptic or Other Seizures? __ No __ Yes (explain)_____

Other Medical Conditions (including diabetes, psychiatric treatment, recent surgery or major illness):

__ No __ Yes (explain)_____

Please use this space to provide any additional information about participant's behavior and physical, emotional or mental health about which the camp should be aware._____

_____

Allergies: List all known.

Medication allergies (list) Describe reaction and management of the reaction.

_____

_____

Food allergies (list)

_____

_____

Other allergies (list) - including insect stings, hay fever, asthma, animal dander, etc.

_____

Child's Name_____ **Program & Dates Attending Camp:** _____

To Be Completed by the Family Physician

Date of most recent complete exam within the past two years _____

Date of most recent Tetanus toxoid within the past 10 years _____
Other immunizations up to date? __ No __ Yes
Does this child carry an asthma inhaler: __ No __ Yes If yes, does he/she have the knowledge and skills to safely posses and use the asthma inhaler in a farm day camp setting? __ No __ Yes
Comments_____
_____
Does this child carry an Epinephrine Auto-Injector __ No __ Yes If yes, does he/she have the knowledge and skills to safely posses and use the Epinephrine Auto-Injector in a farm day camp setting? __ No __ Yes

Comments _____
_____
Any restrictions to activity? __ No __ Yes If yes,
explain_____

"I have examined the above child within the past two years. In my opinion the child's condition does not preclude his or her participation in an active camp program."

Physician's signature _____Date _____
Please return to: Stonewall Farm, 242 Chesterfield Rd. Keene, NH 03431