



The Cambridge School of Weston

# Student Health Information

## Summer 2012

### CAMPER

<b>First Name:</b>	<b>Last Name:</b>	<b>Nickname:</b>
<b>Home Phone:</b>	<b>Age:</b>	<b>Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female
<b>Street Address:</b>		
<b>City:</b>	<b>State:</b>	<b>Zip Code:</b>
<b>International:</b>		
<b>Program Attending:</b> <input type="checkbox"/> Art Squad (6 & 7) <input type="checkbox"/> Summer Arts (8-15)		
<b>Weeks Attending:</b> <input type="checkbox"/> Week # 1 (June 25 - 29) <input type="checkbox"/> Week # 4 (July 16 - 20) <input type="checkbox"/> Week # 2 (July 2, 3, 5, 6) <input type="checkbox"/> Week # 5 (July 23 - 27) <input type="checkbox"/> Week # 3 (July 9 - 13)		

### FIRST PARENT/GUARDIAN

<b>First Name:</b>	<b>Last Name:</b>	<b>Email Address:</b>
<b>Home Phone:</b>	<b>Work Phone:</b>	<b>Cell Phone:</b>
<b>Street Address:</b> <input type="checkbox"/> SAME AS CAMPER		
<b>City:</b>	<b>State:</b>	<b>Zip Code:</b>

### SECOND PARENT/GUARDIAN

<b>First Name:</b>	<b>Last Name:</b>	<b>Email Address:</b>
<b>Home Phone:</b>	<b>Work Phone:</b>	<b>Cell Phone:</b>
<b>Street Address:</b> <input type="checkbox"/> SAME AS CAMPER		
<b>City:</b>	<b>State:</b>	<b>Zip Code:</b>

### MEDICAL INFORMATION

<b>Insurance Carrier:</b>	<b>Group Number:</b>
<b>Subscriber Name:</b>	
<b>General Practitioner/Pediatrician Name:</b>	<b>Phone:</b>
<b>Dentist Name:</b>	<b>Phone:</b>
<b>Medications to Administer during camp hours:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, please list: If yes, an adult must hand deliver the medication to Summer Arts RN on student's 1st day and complete a form at same time.	

**CONCERNS AND COMMENTS**

Please share details regarding the following categories, which will provide insight into your child's needs. Please use reverse of this sheet if you need more room.

<input type="checkbox"/> <b>Asthma:</b>	<input type="checkbox"/> <b>Serious Illnesses:</b>
<input type="checkbox"/> <b>Allergies:</b>	<input type="checkbox"/> <b>Behavioral (optional):</b>
<input type="checkbox"/> <b>Epi Pen:</b>	<input type="checkbox"/> <b>Social (optional):</b>
<input type="checkbox"/> <b>Physical Concerns or Limitations:</b>	<input type="checkbox"/> <b>Learning Styles (optional):</b>

**FIRST EMERGENCY CONTACT (IN CASE PARENT(S)/GUARDIAN(S) CAN NOT BE REACHED)**

<b>First Name:</b>	<b>Last Name:</b>	<b>Relationship:</b>
<b>Home Phone:</b>	<b>Work Phone:</b>	<b>Cell Phone:</b>
<b>May pick up participant:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		

**SECOND EMERGENCY CONTACT (IN CASE PARENT(S)/GUARDIAN(S) CAN NOT BE REACHED)**

<b>First Name:</b>	<b>Last Name:</b>	<b>Relationship:</b>
<b>Home Phone:</b>	<b>Work Phone:</b>	<b>Cell Phone:</b>
<b>May pick up participant:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		

**Immunizations Records:** Each student must have immunization records on file at Summer Arts, dated on or after June 25, 2010. These may be mailed to the office or faxed to 781-398-8355. Deadline: June 1, 2012. Without immunization records on file a child cannot attend. Camp RN will make only one reminder call to families regarding missing immunization records.

**FOR EACH OF THE AGREEMENTS BELOW, PLEASE READ THE TERMS AND SIGN YOUR NAME TO CONFIRM:**

1. **Over-the-Counter Medications to Administer During Camp Hours:** I give the camp nurse permission to administer Tylenol (Acetaminophen), Advil/Motrin (Ibuprofen), Benadryl (Diphenhydramine), and/or Caladryl anti-itch lotion as deemed necessary. Dosages are within manufacturers guidelines and approved by the camp physician. My child is allowed to use sunscreen (sensitive skin formula) available in the nurse's office if it is forgotten at home.

I agree to full list of medications listed here.    I do not agree.

I agree to only the following medication(s): \_\_\_\_\_

**Signature\* of Parent or Guardian:** \_\_\_\_\_

2. **Emergency Care Authorization:** I understand that health information will be shared on a need to know basis with camp staff. I understand that in the event that my child becomes seriously injured or ill at camp, s/he will be transported to Newton Wellesley Hospital for treatment. I understand that emergency medication/treatment may be administered at the discretion of licensed health care personnel. Parents/guardians will be notified as soon as possible using contact information from camper's registration form. I understand that any charges incurred will be billed to me.

**Signature\* of Parent or Guardian:** \_\_\_\_\_

**Signature\* of Parent or Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Printed Name:** \_\_\_\_\_

\* Signatory must be older than 18 years