OLD BARRACKS MUSEUM
TRENTON, NJ

Old Barracks Museum
Attn: Summer Camp
101 Barracks St
Trenton, NJ 08608
609-396-1776

Dates will attend camp: from _____ (Month/Day/Year) to _____ (Month/Day/Year)

Camper Name: _____ (First) (Middle) (Last)

☐ Male ☐ Female Birth Date _____ (Month/Day/Year) Age on arrival at camp: _____

To Parent(s)/Guardian(s): Please follow the instructions below. Attach additional information if needed.

1) ***Complete pages 1 and 2 of this form and make a copy.***
2) ***Send the original, signed form to Old Barracks Museum, Attn: Summer Camp, 101 Barracks St, Trenton, NJ 08608 by the requested date.***
3) ***Campers will not be permitted to attend without completed forms.***

Camper Home Address: _____ (Street Address) (City) (State) (Zip Code)

Parent/guardian with legal custody to be contacted in case of illness or injury:

Name: _____ Relationship to Camper: _____ Preferred Phones: (_____) _____ (_____) _____

Email: _____

Home Address: _____ (If different from above) (Street Address) (City) (State) (Zip Code)

Second parent/guardian or other emergency contact:

Name: _____ Relationship to Camper: _____ Preferred Phones: (_____) _____ (_____) _____

Email: _____

Additional contact in event parent(s)/guardian(s) can not be reached:

Name: _____ Relationship to Camper: _____ Preferred Phones: (_____) _____ (_____) _____

Allergies: ☐ No known allergies. ☐ This camper is allergic to: ☐ Food ☐ Medicine ☐ The environment (insect stings, hay fever, etc.) ☐ Other
(Please describe below what the camper is allergic to and the reaction seen.)

Diet, Nutrition: ☐ This camper eats a regular diet. ☐ This camper eats a regular vegetarian diet. ☐ This camper is lactose intolerant. ☐ This camper is gluten intolerant. ☐ Other, ***please explain in space.***

Restrictions:

☐ I have reviewed the program and activities of the camp and feel the camper can participate without restrictions.

☐ I have reviewed the program and activities of the camp and feel the camper can participate with the following restrictions or adaptations. ***(Please describe below.)***

Medical Insurance Information:

This camper is covered by family medical/hospital insurance ☐ Yes ☐ No

Include a copy of your insurance card if appropriate; copy both sides of the card so information is readable.

Insurance Company_____ Policy Number_____

Subscriber_____ InsuranceCompany Phone Number (_____)_____

Parent/Guardian Authorization for Health Care:

This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

Signature of Custodial Parent/Guardian _____ Date: _____ Relationship to Camper: _____

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

CAMPER HEALTH HISTORY FORM 1

Developed and reviewed by: *American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses*

Camper Name: _____
First Middle Last

Birth Date: _____
Month/Day/Year

Immunization History: Provide the month and year for each immunization. Starred (★) immunizations must include date to meet ACA Standard. Copies of immunization forms from health-care providers or state or local government are acceptable; please attach to this form. (In some cases, copies of Immunization records can be obtained from school records as well as your physician's office)

Immunization	Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most Recent Dose Month/Year
Diptheria, tetanus, pertussis (DTaP) or (TdaP)						
Tetanus booster★ (dT) or (TdaP)						
Mumps, measles, rubella (MMR)						
Polio (IPV)						
Haemophilus influenzae type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox) ☐ Had chicken pox Date:						
Meningococcal meningitis (MCV4)						

Tuberculosis (TB) test	Date:	☐ Negative ☐ Positive

Medication

☐ This camper will not take any daily medications while attending camp.

☐ This camper will take the following daily medication(s) while at camp:

If this camper will be taking medication while attending camp, please explain:

Name of medication: _____ **Reason for taking it:** _____

Amount or dose given: _____ **Method for giving it:** _____

The following non-prescription medications may be stocked in the camp Health Center and are used on an as needed basis to manage illness and injury. ***Cross out those the camper should not be given.***

Acetaminophen (Tylenol)
Antihistamine/allergy medicine
Calamine lotion
Ibuprofen (Advil, Motrin)
Antibiotic cream
Aloe

For female campers:

Has she menstruated? _____yes _____no If not, has she been told about it? _____yes _____no Special considerations? _____

Health-Care Providers:

Name of camper's primary doctor(s): _____ Phone: (_____) _____

Name of dentist(s): _____ Phone: (_____) _____

Name of orthodontist(s): _____ Phone: (_____) _____

Authorization for Pediatric Medical Emergency Medical and/or Surgical Treatment Explanation: For the safety of children, sound medical practice calls for this authorization which is crucial to the Old Barracks' preparedness in the event of an emergency. In emergencies, where the Parent'Legal Guardian of the child cannot be reached - this form will be extremely important. The authorization granted by this form will be used only when absolutely necessary and only after every attempt has been made first to contact the Parent/Legal Guardian.

I hereby give my permission for my child to attend the Old Barracks Summer Day Camp. This Health History is correct so far as I know, and the child herein described has permission to engage in all prescribed camp activities except as noted.

I hereby authorize the Old Barracks Association to take measures in the event of a medical emergency. I hereby give permission to the medical personnel selected by the Old Barracks Association Camp Staff to order x-rays, routine tests, treatment, and necessary related transportation for me and/or my child.

In the event that I cannot be reached in an emergency, I hereby give permission to the Physician selected by the Camp Staff to secure treatment including hospitalization, for my child as named above.

Parent/Legal Guardian Signature: _____ **Date:** _____

Physician Signature (not required if official medical forms are attached) : _____ **Date:** _____