GREENSBORO
Parks & Recreation

MEDICAL INFORMATION

Must be completed and received to secure a confirmed spot at Camp Joy.

Camper Name_______________________________________ Date of Birth________________________

Please check all that apply:

____Allergies	____Diagnosed Disability (specify)	____Hearing Aid	____Scoliosis
____Arthritis	____Diabetes	____Heart Condition	____Seizures
____Asthma	____Diet Restriction	____Hemophilia	____Shunt
____ Autism	____Ear Tubes	____High Blood Pressure	
____Braces (orthopedic)	____Fainting	____Learning Disability	____Other
____Developmental Disability	____Glasses	____Poor Bladder Control	____________

Please provide specific information for medical conditions we should be aware of (allergies, activity restrictions, disabilities, etc.):
____
____

Are immunizations up to date? _______Yes No

IMPORTANT: Please notify camp if this camper is exposed to any communicable disease during the three weeks prior to attendance at camp.

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MEDICAL RECORD (required)

CURRENT FOR 3 YEARS FROM THE DATE OF THE EXAMINATION. PLEASE INFORM US OF ANY MEDICAL UPDATES AS NECESSARY.

PHYSICAL EXAMINATION: MUST BE COMPLETED BY A LICENSED PHYSICIAN

Height________ B/P__________ Urinalysis test done___________________________
Weight________ HGB test done____________________ Tetanus_________________________
Eyes____________________________ Glasses_____________________________________
Extremities_______________________ Posture_____________________________________
Ears________ Skin____________ Nose___________
Throat__________ Teeth___________ Heart___________
Lungs__________ Abdomen________ Genitalia________
Hernia__________

Allergies (Please specify):
____

General Appraisal (Recommendations and Restrictions):
____
____

Medications (Please list type, dosage, and frequency given):
____
____

Physician's Name (please print)____
Signature:____
Date of Exam___________________________________ Phone Number:___________________________
Address____
____

FAX NUMBER FOR CAMP JOY – 336-373-2943

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PERMANENT IMMUNIZATION RECORD (required)

Camper's Name_____________________________________ Date of Birth______________

Instructions: Please provide the following information concerning the above named camper's immunization record. This will be kept on permanent file in the Camp Joy office and will not have to be completed again as part of future Camp Joy registration forms.

FOR CAMPERS WHO HAVE BEEN TO CAMP JOY AND ALREADY SUBMITTED THIS FORM: If the camper's immunization record has been updated, please submit a copy of the updated information.
*** Measles, Mumps, Rubella. If given separately, please indicate below.**

Please list the dates that this camper received the following immunizations:

DTP __________ __________ __________ __________ __________

Polio __________ __________ __________ __________ __________

MMR* __________ __________ __________ __________ __________

Haemophilus influenza type b (Hib)_________ __________ __________ __________

Chicken Pox __________ __________ __________ __________ __________

Hepatitis B __________ __________ __________ __________ __________

Other (please specify and give dates):____
____

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