

**BOYS' AND GIRLS' CLUB HEALTH FORM- to be filled out by parent/guardian:**  
16 MELVILLE STREET, PITTSFIELD, MA 01201

DATE \_\_\_\_\_

CAMPER \_\_\_\_\_ AGE \_\_\_\_\_ SEX \_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

PARENT/GUARDIAN \_\_\_\_\_

ADDRESS IF DIFFERENT THAN ABOVE \_\_\_\_\_

PHONE \_\_\_\_\_

IF NOT AVAILABLE IN AN EMERGENCY, NOTIFY;

NAME \_\_\_\_\_ ADDRESS \_\_\_\_\_

PHONE \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

**HEALTH HISTORY(CHECK W/APPROX. DATES)**

Frequent Ear Infections \_\_\_\_\_ Heart Defect Disease \_\_\_\_\_

Seizure Disorder \_\_\_\_\_ Diabetes \_\_\_\_\_ Asthma \_\_\_\_\_

Bleeding/clotting disorder \_\_\_\_\_

Details of above checked items \_\_\_\_\_

**ALLERGIES:**

Peanut \_\_\_\_\_ Antibiotics \_\_\_\_\_ Other \_\_\_\_\_

Is your child on any medication? Yes \_\_\_ No \_\_\_ If yes, explain \_\_\_\_\_

Please add any additional developmental or medical information you feel we should know \_\_\_\_\_

Insects/Bee Stings \_\_\_\_\_ list treatments being used \_\_\_\_\_

(is child being desensitized?) \_\_\_\_\_

List Operations/serious injuries \_\_\_\_\_

Chronic/recurring illness \_\_\_\_\_

Source of Medical Care \_\_\_\_\_ Phone \_\_\_\_\_

Source of Dental Care \_\_\_\_\_ Phone \_\_\_\_\_

Any Specific activities to be encouraged or restricted? \_\_\_\_\_

I hereby authorize the Camp Director to take any necessary action in case of emergency:

**Signature of parent /guardian** \_\_\_\_\_

**\*\*PARENTAL PERMISSION FOR DISPENSING MEDICATIONS:**

I authorize the camp nurse to see that my child \_\_\_\_\_

receives medication prescribed by (Physician) \_\_\_\_\_

This medication is to be supplied by parent/ guardian properly labeled with the camper's name, directions & physician's name. MEDICATION MUST ARRIVE ON THE FIRST DAY OF CAMP WITH SUFFICIENT MEDS FOR ENTIRE SESSION OF CAMP ( INCLUDES INHALERS).

Signature of parent/  
guardian \_\_\_\_\_ Date \_\_\_\_\_

Name of medication \_\_\_\_\_

Dose of medication \_\_\_\_\_

Directions: \_\_\_\_\_

**BOYS' & GIRLS' CLUB CAMP RUSSELL HEALTH FORM**

16 MELVILLE ST. PITTSFIELD, MA 01201  
TEL. 448-8258 FAX 44-55579

**TO BE FILLED OUT BY PHYSICIAN AND RETURNED TO US:**  
( copy of records or immunizations may be attached )

**CAMPER'S NAME** \_\_\_\_\_

I have examined the above camper and I find him/her to be fit and able to enjoy camp life to the fullest extent. ALL IMMUNIZATIONS ARE UP TO DATE.

\_\_\_\_\_ Date \_\_\_\_\_  
Signature of Physician

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