____ Reviewed by Group Health Supervisor (Please Check)
Name: ______________________

BOSTON SCHOOL FOREST
HEALTH INFORMATION FORM

Each camper MUST have 2 paper copies of a health information form completely filled out and signed by a parent/guardian. This health information form must be on file at the school forest during the time that the group is using the facility. A health information form must be kept on file by the SPAPSD/Boston School Forest for 2 years for each camper each stay, according to state code.

Name ________________________________ Age ___________ Phone ____________________

Address __________________________ City ____________________ State _____ Zip ______

Organization ____ Date of Program ____________

Emergency Contact Person ______________________________ Phone ___________________

Insurance Company __________________________ Identification Number ________________

Does the camper take any medication(s)? Yes ______ No ______ (see below)

I give permission for my child to receive emergency medical care:

____________________________________ ____________________

Parent/Guardian Signature Date

All prescription medications must be brought to camp in their ORIGINAL CONTAINER. THE CONTAINER MUST BE LABELED BY THE PHARMACY WITH THE CURRENT DOSAGE. Any changes from those on the container must be verified in writing by a physician. All vitamins, over the counter medication, preparations and homeopathic remedies must be brought in their original containers. The Health Care Staff is required to dispense medications as directed by a physician.

1. All medications (including over the counter pills, vitamins and treatments) must be turned over to the health care supervisor upon registration.

2. All medications will be administered under the direction of the health care staff.

3. All medications should be labeled clearly with the camper's name, name of the drug, dosage and time to be taken. Please provide an adequate supply.

4. Do not record insulin schedule below.

Name of Medication/Treatment	Ailment	Dosage	Date	Time	Date	Time	Name of whom administered

Comments: ____

5. Does the camper experience any side effects from the medication?
   Yes ______ No ______ (i.e.: mood or behavior changes, upset stomach, diarrhea, etc.)
   If yes, what should be done about this? ____

6. List below any special instructions or additional information regarding the medication that would be helpful to the health care supervisor. ______________________________
   ____

7. **Allergies**: Do you have any allergies (e.g. bees, drugs, food, etc.)? If so, what are they?
   ____
   ____

8. **Medications**: Are you taking medication (e.g. Tylenol, Orthonovo 777, Proventil, etc.)? If so, what are they? What are they for? ______________________________________
   ____

9. **Chronic Illness**: Do you have any chronic illness (e.g., diabetes, epilepsy, asthma, etc.)? ____
   ____

10. **Physical Conditions**: Do you have any physical conditions that might limit or prevent you from participating in certain physical activities? If so, please describe. __________
    ____

11. **Injuries**: Have you experienced any injuries (e.g. dislocations, sprains, etc.) within the last three years? If so, list here and identify when the injuries occurred and the extent or the severity of the injury. Have you fully recovered from this injury? ____________
    ____

12. **Physician**: Have you been treated by a physician in the past year? Have you been hospitalized within the past year? If so, explain. ________________________________
    ____

Have you had any of the following in the last 24 hours?

	Yes	No	Explain
Fever			
Vomiting			
Dizziness			
Sore Throat			
Cough			

Comments: Is there any other information we should know? ______________________________
____
____