Camp Duffield Registration Form (Please print)-page A **Date: _____**

Name of Camper: Last_____First_____

Home Address:_____
Street City State Zip

Home Phone# _____Sex _____DOB: ___/___/____ Grade Completed _____

Parents/Guardians: _____

Cell Phone# Mom: _____ Dad:_____

Parents email: _____Camper email:_____

Emergency Contact Information: (If unable to reach a parent, someone who is available 24/7)

Contact name_____Phone:_____Relationship_____

Contact name_____Phone:_____Relationship_____

Campers Physician: _____ Phone: _____

Physicians Address: _____
Street City State Zip

Chipmunks camp includes required parent stay and needs additional forms.

Camp	Date of Camp Circle one	Paid in Full by May 1st	Paid in Full by June 1st	Office Use Only (Date Received)
First Timers Grades 1st - 2nd	July 12 - 15 July 19 - 22	$280	$300	
Science Grades 3rd - 8th	July 12 - 18	$380	$400	
Music Grades 3rd -8th	July 19 - 25	$380	$400	
Night Owls Grades 8rd -12th	July 26 - Aug 1	$380	$400	
Impact 716 Grades 3rd – 12t	August 1 – 7	$380	$400	

Camper's Tee-Shirt Size _____

Fees and all forms must be completed and turned in by June 1st .
Send to: Duffield Summer Camps, P.O. Box 55, Kenmore, NY, 14217

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Camp Duffield Registration Form (Please print)-page B **Date:_____**

Name of Camper:_____
Has camper traveled outside the country in the past 9 months? _____
When/Where _____

1.	Has camper had a recent injury, illness or infectious disease?	☐ Yes ☐ No
2.	Are there any chronic or recurring illness/condition?	☐ Yes ☐ No
3.	Has camper been hospitalized or had any surgery?	☐ Yes ☐ No
4.	Does camper have frequent headaches	☐ Yes ☐ No
5.	Ever had a head injury or been knocked unconscious?	☐ Yes ☐ No
6.	Wear glasses or contacts	☐ Yes ☐ No
7.	Ever had frequent ear infections?	☐ Yes ☐ No
8.	Ever pass out or been dizzy during or after exercise?	☐ Yes ☐ No
9.	Ever had seizures or convulsions?	☐ Yes ☐ No
10.	Ever had chest pains or diagnosed with a heart condition?	☐ Yes ☐ No
11.	Any physical or mental disabilities? Explain below.	☐ Yes ☐ No
12.	Ever had an eating disorder?	☐ Yes ☐ No
13.	Ever had back or joint problems?	☐ Yes ☐ No
14.	Have any skin problems?	☐ Yes ☐ No
15.	Bringing an orthopedic device to camp?	☐ Yes ☐ No
16.	Have asthma?	☐ Yes ☐ No
17.	Have diabetes?	☐ Yes ☐ No
18.	Problems with sleepwalking or bed wetting?	☐ Yes ☐ No
19.	Had mononucleosis in past 12 months?	☐ Yes ☐ No
20.	Had problems with diarrhea/constipation?	☐ Yes ☐ No
21.	If female – abnormal menstrual history?	☐ Yes ☐ No
22.	Been involved in bullying or been bullied?	☐ Yes ☐ No
23.	Ever had a emotional problems for which professional help sought?	☐ Yes ☐ No
24.	Hay fever or other allergies?	☐ Yes ☐ No
25.	Bee sting reactions?	☐ Yes ☐ No
26.	On a special diet, vegetarian, lactose free, gluten? Explain below	☐ Yes ☐ No
27.	Any other facts we need to know:	☐ Yes ☐ No

Explain yes answers here:

_____

_____

Authorizations: This health history is correct and complete to the best of my knowledge, and the person herein described has permission to engage in all camp activities . I hereby give permission to the medical personnel selected by the Camp Director to secure proper treatment and transportation, for my child named above if deemed necessary and to share their medical information for this purpose. I also give permission for my camper's picture to be used in promotional materials and distributed to campers and staff at the end of camp session.

_____ _____

Signature of parent or guardian **Date**

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Camp Duffield Registration Form (Please print)-page C

Authorization from Parent/Guardian for person to

Consent for treatment of minor patient

I, _____do hereby authorize Camp Duffield Staff to sign for any Medical Treatment deemed necessary for (print child name) _____, whose birth date is __/__/_____. This authorization is valid from (date) _____ through and including _____.

Today's Date_____

Parent/Guardian_____ **Print**

Parent/Guardian_____ **Signature**

The person herein described has appeared before me and is known by me or has presented Sufficient identification to prove, that he or she, is indeed, the above individual.

Notary Public Signature/Stamp/Date: "MUST BE COMPLETED

Health Insurance Company_____

Name of insured _____ Relationship to camper _____

Identification Number _____Group No._____

Place of Employment_____

Camper Physician: Phone _____

A photocopy of insurance card is required to attend camp.

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Camp Duffield Health History

Name of Camper: _____DOB_____/_____/

Date of physical: _____/_____/_____ (physical must be within past calendar year)

Has camper been hospitalized within the past 3 years? _____

If yes explain details and dates: _____

Patient's: HT _____ WT _____ P _____ BP _____/_____RR _____

PHYSICAL EXAMINATION

SYSTEM	WITHIN NORMAL	ABNORMAL	EXPLAIN REASON
HEAD, NECK			
EARS,NOSE,THROAT			
LUNGS			
HEART			
ABDOMEN			
GENITALIA			
SPINE			
EXTREMITIES			
NEURO			
SKIN			
EYES			

MEDICATIONS

Please list all medications (including over the counter or non prescription drugs) being taken. Bring enough medication to last the entire time at camp. Keep in original packaging/bottle that identifies the medication, the prescribing doctor, the dosage and frequency of administration.

MEDICATION	DOSAGE	TIMES GIVEN	REASON	SPECIAL INSTRUCTIONS

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Physician's Report page 2 of 4

Camp Duffield Health History

Name of Camper: _____DOB____/____/_____

Immunization History: Provide the **month and year for each immunization.** All immunizations must be current. Copies of immunization records from health-care providers are preferred.

Immunization (List or attach doctors records of immunizations)

DTaP or TdaP _____
MMR _____
IVP _____
HIB _____
RV _____
Hepatitis A _____
Hepatitis B _____
Varicella _____
Meningococcal _____
Covid _____

Allergy Information: _____ Does not apply (no allergies please check)

Allergy to:	Reaction:	Treatment:
Seasonal:		
BEES		
Animals:		
Food:		
Food:		
Medication:		
Medication:		
Other		
Other		

Children required to carry epi pen, must bring the epi pen and physician's Rx.
Peanut orTree nut allergies please bring report from doctor as to allergy.

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Camp Duffield Health History

Name of Camper: _____DOB____/____/_____

OVER THE COUNTER MEDICATION FORM
Your medical doctor must complete this form

I hereby authorize that the following medications may be given to the above named camper at Camp Duffield after nursing assessment.

Bactine (topical) for minor wound care, first aid as needed

Triple Antibiotic Ointment (topical) for wound healing

Tylenol (oral) as directed on bottle

Ibuprophen (oral) as directed on bottle

Cough Drops for coughing, minor throat irritation as needed

Antacid Tablet (oral) for stomach discomfort

Benydryl (oral or topical) for swelling, hives, and allergic reaction as directed on bottle

Calamine Lotion or Cortaid (topical) for insect bites/bee stings

Visine/ Murine Plus Eye Drops (topical in eye) for minor eye irritation

Other (please describe) _____

_____

PHYSICIAN CONSENT

Physician Signature _____ Date _____

Printed Name _____ License Number _____

Address _____Phone _____

City _____ State _____ Zip _____ Fax _____

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Camp Duffield Health Medication Forms

Name of Camper: _____DOB___/___/_____

For Prescription Medications:

Any use of prescription drugs must be ordered by the Camper's Physician and brought in original container. This form must be completed **for each prescription** to be administered and signed by the Camper's Physician.

For Over-the Counter Medications:
Any additional over-the-counter medication not listed on page 3 must have specific directions and be in the original container . This form needs to be completed **for these over-the-counter medication** the Camper uses.

Please give the following medications to the above named Camper:

Name of Prescription Medication:_____

Dosage of Drug:_____

Times to be administered:_____

Length of time drug is to be given:_____

Special instructions:_____

PHYSICIAN CONSENT

Physician Signature _____ Date _____

Printed Name _____ License Number _____

Address _____Phone _____

City _____ State _____ Zip _____ Fax _____

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