HEALTHY HISTORY & MEDICAL AUTHORIZATION FORM FOR ALL PERSONS UNDER THE AGE OF 18

Registration will NOT be processed unless it is accompanied by this form. NOTE: A doctor's signature is NOT required.

NAME OF CAMPER: _____ _____ _____ _____
Last First MI Home Phone

_____ _____ _____ _____
Street Address City State Zip

CAMPER'S SOCIAL SECURITY #_____ CAMPER'S DATE OF BIRTH_____

CAMPER'S GENDER: ❑ Male ❑ Female CAMPER'S AGE: _____ GRADE ENTERING AS OF SEPTEMBER 2016: _____

PARENT NAME: _____ Daytime Phone: _____

E-Mail Address: _____

PARENT NAME: _____ Daytime Phone: _____

E-Mail Address: _____

ALT. EMER. CONTACT: _____ Daytime Phone: _____

FAMILY PHYSICIAN: _____ Daytime Phone: _____

PLEASE COMPLETE THE FOLLOWING:

Withholding relevant physical, emotional and mental health history may result in exclusion from camp. Specify all known conditions such as ADD/ADHD in #1 below. A camper whose presence poses a continuing danger to persons or property, or an ongoing threat of disrupting the camp experience for others, will be excluded from activities and expelled from camp.

ALL MEDICATIONS INCLUDING INHALERS & EPI PENS, MUST BE STORED & WILL BE ADMINISTERED BY CAMP MEDICAL STAFF

1. Currently under physician's care for: _____
2. Current medication being taken (including medication taken during the school year): _____ ❑ NONE
3. Were you ever advised not to allow this child to play in any sports? ❑ YES ❑ NO
4. List any medical conditions: _____
5. List any allergies including bee stings, hives, asthma _____
   Circle: Child uses epi pen / Child uses an inhaler (Indicate type) _____
   Child can use this independently ❑ YES ❑ NO
6. Has this child:
   (a) had difficulty with sight? ❑ YES ❑ NO
   (b) had difficulty with hearing? ❑ YES ❑ NO
7. Does this child have a history of fainting with exercise? ❑ YES ❑ NO
8. Has child experienced recent loss of family member or close friend? ❑ YES ❑ NO

According to state law, all campers must be immunized or submit a statement indicating REFUSAL TO VACCINATE. Provide dates for each immunization. DO NOT attach additional pages of the health history record from your doctor's files. Only the dates of vaccination are pertinent. For a copy of the Refusal to Vaccinate form please call (732) 502-2255

Immunization For:	**Dates of Vaccination (month/year):**			
Diphtheria, Tetanus, Pertussis (DTaP) or (TdaP)	_____	_____	_____	_____
Mumps, Measles, Rubella (MMR)	_____	_____	Haemophilus Influenza Type B (HIB)	_____
Pneumococcal (PCV)	_____	_____	Polio (IPV)	_____
Hepatitis A	_____	_____	Hepatitis B	_____
Varicella (Chicken Pox)	_____	_____	Meningococcal Meningitis (MCV4)	_____
Last TB/Tetanus Booster	_____			

RELEASE AUTHORIZATION

Children will only be released to individuals who are authorized. If you wish to have your child picked up by individuals not on this list, you must provide the camp with a revised authorization list 48 hours before pick-up date.

_____ _____ _____
Name Relationship Phone #

_____ _____ _____
Name Relationship Phone #

If an emergency illness or injury occurs, I (parent/guardian) hereby authorize Hoop Group to treat and/or send this person to a physician or hospital and authorize the necessary treatment. I also authorize the physician or hospital to release my child after treatment to a representative of Hoop Group. All information on this form is complete, true and accurate to the best of my knowledge.

_____ _____
SIGNATURE OF PARENT/GUARDIAN DATE

CAMP MEDICATION POLICY

It is the policy of Hoop Group to discourage children from taking medication while attending camp. However, if your child has a chronic health condition (e.g: seizure disorder, ADD, ADHD, Diabetes, epi pen, inhaler, etc.) or is presently being treated for an episodic illness which necessitates him/her taking medication during camp hours, please contact the Camp medical staff at 732-502-2255. This signed document and any medication the camper will be taking must be given to the medical staff prior to the start date of your child's camp.

All medication must be stored with the Camp medical staff. Medication will be administered only upon written order of the prescribing physician and at the request of the parent/guardian, giving permission to administer the medication and releasing the camp staff for **ALL** liability for administration of the medication as specified. Medication shall be given to Camp medical staff **ONLY** in a labeled prescription bottle.

Camper: _____

Diagnosis: _____

Medication name & Dosage: _____

Time to be given: _____

_____ _____

Signature of Physician Date

I hereby give permission to the Hoop Group Medical staff to administer medication to my child as directed by the physician.

I release Hoop Group/Hoop Group medical staff of all liability for the administration of medication as specified above.

_____ _____

Signature of Parent/Guardian Date

SELF ADMINISTRATION - EPI PEN - INHALER - INSULIN ONLY

PERMISSION FORM – SELF MEDICATING

I, _____ parent/guardian of _____
give permission for my child to carry_____.
(name of medication)

My child is aware of the dosage and has been instructed on how to use the medication by our private physician and myself. My child understands those instructions and demonstrates proper use of the medication. My child is aware of situations that require further medical attention.

_____ _____ _____
Camper Age Weight

Diagnosis: _____

Allergy: _____

_____ _____
Signature of Parent/Guardian Date

I understand that Hoop Group shall not incur any liability as a result of injury arising from my decision to permit my child to self-medicate.

Please provide a second epi pen/inhaler/insulin to be kept with Camp medical staff in the event that your child forgets his/her medication. **Medication must be in a labeled prescription box or bottle.**

PHYSICIAN PERMISSION

I have instructed both the parent and the child in the administration of _____ (name of medication and dosage) and feel that this child may carry the medication on their persons and self-medicate as needed.

_____ _____
Signature of Physician Date

SELF ADMINISTRATION - EPI PEN - INHALER - INSULIN ONLY

PERMISSION FORM – CHILD CANNOT SELF MEDICATE

I, _____ parent/guardian of _____ am aware that my child can carry their own epi pen/inhaler with them while they attend camp. **I DO NOT WANT MY CHILD TO SELF MEDICATE.** My child will carry their epi pen/inhaler with them, but a second one will be stored with medical staff. My child's medication will be administered only when necessary, by Hoop Group Camp medical staff and only upon written order to administer these emergency medications according to the physician's directions and release Hoop Group medical staff from all liability for administering the medication as specified.

_____ _____ _____

Camper Age Weight

Diagnosis: _____

Allergy: _____

_____ _____

Signature of Parent/Guardian Date

Please provide a second epi pen/inhaler/insulin to be kept with Camp medical staff in the event that your child forgets his/her medication. **Medication must be in a labeled prescription box or bottle.**

PHYSICIAN PERMISSION

_____ _____

Camper Date

_____

Diagnosis

_____

Name of medication & Dosage

_____

Instructions for administration

_____ _____

Signature of Physician Date