

Peninsula Bay Cities Day Camp

(310) 541-3664 / FAX (310) 541-3125

Mailing Address:

P.O. Box 5229
Palos Verdes, CA 90274

Campsite:

Marymount College
30800 Palos Verdes Drive E, RPV

CHILD'S HEALTH HISTORY FORM FOR COMPLETION BY THE PARENT OR GUARDIAN

Last Name _____ First Name _____ Nickname _____

____ Male ____ Female Birth date _____ Age _____ Grade in September _____ School _____

Parent or Guardian _____ Day Phone () _____ Home Phone () _____ Cellular Phone () _____

Address _____ City _____ ST _____ Zip _____

Mother's employer _____ Mother's Day Phone () _____ Mother's Home Phone () _____

Father's employer _____ Father's Day Phone () _____ Father's Home Phone () _____

Physician _____ Phone () _____

Emergency Contact other than parent _____ Phone () _____ Relationship _____

Health Insurance Carrier _____ Policy Number _____

Health History (please check where applicable)		What was the date of your child's last physical examination? _____		
<input type="checkbox"/> Frequent ear infection	<input type="checkbox"/> Heart defect/disease	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Bleeding/clotting	<input type="checkbox"/> Asthma
<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Loss of consciousness	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Seizures	<input type="checkbox"/> Other _____
Please explain any items checked on the back of this form				

Immunization (please list month/year): Hepatitis B _____ Polio _____ DTP _____ HIB _____ MMR _____ Tetanus _____

Diseases (please list month/year): Chicken Pox _____ Measles _____ German Measles _____ Mumps _____ Tuberculosis _____

Does your child have any physical limitations or allergies? ____Yes ____No If Yes, please describe: _____

Does your child have any disability, chronic or recurring illness? ____Yes ____No If Yes, please describe: _____

Are there any Camp activities in which your child **cannot** participate? ____ Yes ____No If Yes, please describe: _____

Activities encouraged or limited by your physician: _____

Is your child taking any medications which need to be dispensed at camp? ____Yes ____No If Yes, a **Medication Information Form** (available from the camp office) must be completed and sent to camp along with the appropriate medicine. _____

This Health History is correct as far as I know and the person herein described has permission to engage in all prescribed camp activities **except as noted IN WRITING. Authorization for Treatment:** I hereby give permission to the medical personnel selected by the camp director to order x-rays, routine tests, treatment, to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me or my child. In the event I cannot be reached in an emergency, I hereby give my permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for the person named above. I understand that my insurance carrier will be used for primary coverage and the Camp's insurance as secondary coverage. However, I shall be responsible for all costs incurred for the treatment of my child whether or not they are covered by insurance.

Parent or Guardian's signature _____ Printed name _____ Date _____

We rely on this form for your child's health and safety, therefore, we must be notified of any changes immediately and IN WRITING.