



MEDICAL/EMERGENCY CONTACT FORM
**** Must be completed by Parent ****

P.O. Box 750, Freeport, New York 11520 Telephone: (516) 623-4550 Fax: (516) 223-1568 Email: camp.twinoaks@gmail.com

Name of Camper:	Date of Birth:
Street Address:	
City, State, ZIP:	Phone:

IN CASE OF ACCIDENT, NOTIFY:

Mother's Name	Daytime Phone	Mobile Phone
Father's Name	Daytime Phone	Mobile Phone
Alternate 1 (state relationship to child)	Phone	
Alternate 2 (state relationship to child)	Phone	
Name of Insurance Company	Phone	
Insurance ID Number	Name of Insured	DOB
		Occupation

IF NO ONE IS HOME TO RECEIVE CAMPER, MY CHILD MAY BE LEFT WITH THE FOLLOWING NEIGHBOR:

Name	Phone
Address	

I hereby authorize Twin Oaks Day Camp to arrange for emergency medical treatment for my child, while my child is under the Camp's care. Twin Oaks will contact me in the event of an emergency.

Parent's Signature _____ Date _____

MEDICAL REPORT TO BE COMPLETED BY DOCTOR (include immunization dates)

DPT	1st	2nd	3rd	Booster	Booster	Hepatitis B	1st	2nd	3rd
Polio	1st	2nd	3rd	Booster	Booster	MMR	1st	2nd	3rd
HiB*	1st	2nd	3rd	4th	*conjugate preferred	Chicken Pox (Varicella)	Date		
Pneumococcal	1st	2nd	3rd	4th	Tuberculin Test (type)	Results	Date		

PHYSICAL EXAMINATION: (Please check and descibe positive findings)

HEIGHT	WEIGHT	SKIN & SCALP
NOSE & THROAT	HEART & LUNGS	ABDOMEN
Allergies?	<input type="checkbox"/> Y <input type="checkbox"/> N	Describe:
Special Diet?	<input type="checkbox"/> Y <input type="checkbox"/> N	Describe:
Regular Medications?	<input type="checkbox"/> Y <input type="checkbox"/> N	Describe:
Has child ever had chicken pox?	<input type="checkbox"/> Y <input type="checkbox"/> N	Describe:
Conditions requiring special attention?	<input type="checkbox"/> Y <input type="checkbox"/> N	Describe:
Any Camp activities camper should be exempted from for health reasons?	<input type="checkbox"/> Y <input type="checkbox"/> N	Describe:
Any current physical, mental, or psychological conditions requiring medication, treatment or special restrictions or considerations at Camp?	<input type="checkbox"/> Y <input type="checkbox"/> N	Describe:

Doctor's Name:	Address:	Phone:
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The above named child was examined and found to present no hazard from contagious and communicable disease, is in good health, and is able to participate in customary camp activities.

Signature of Doctor:	Date of Examination:
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*** Physical Exam should be dated ON or AFTER 8/20/20 ***