

RPRY Day Camp

7"טז



2 Harrison St. - Edison NJ 08817
 Phone: 732-572-5052 / Fax: 732-572-3049

This PERSONAL HEALTH and EMERGENCY FORM is to be Submitted with Your Registration/Contract
 If you will be visiting your pediatrician after the deadline dates, please indicate so on this form

Camper/Staff Name:		Date of Birth: ____/____/____
Street Address:	AGE:	Male <input type="checkbox"/>
		Female <input type="checkbox"/>
City, State, Zip:		Home Phone: ()
Mother's Work Phone:	Father's Work Phone:	
Mother's Cell Phone:	Father's Cell Phone:	
Mother's Email: _____@_____	Father's Email: _____@_____	

ADDITIONAL EMERGENCY CONTACT INFORMATION:

Name:	Relationship:
Street Address:	Home phone:
City, State, Zip:	Cell phone:
Name:	Relationship:
Street Address:	Home phone:
City, State, Zip:	Cell phone:
Name:	Relationship:
Street Address:	Home phone:
City, State, Zip:	Cell phone:

Please either complete this page or attach copies of all updated immunizations/physicals onto this form - Thank You.

Camper Name:		
Height:	Weight:	Blood Pressure:
Allergies:		Treatment:
Ocular Pathology/acuity:	Aural Pathology	Skin/Scalp
Abdomen:	Head/Neck:	Lymph Nodes:
Nose/Throat:	Teeth:	Extremities:
Inguinal area:	Lungs:	Genitals:
Heart (any irregularities?) If yes, please explain:		
Injuries, operations? If yes, please explain:		
Orthopedic defects, e.g. Scoliosis: Yes <input type="checkbox"/> No <input type="checkbox"/> Any treatment, please explain:		
Are any medications required to be taken by the camper/staff member? Please specify:		
General condition of the camper/staff member:		
Are there any health findings which might have an effect on the program of the camper/staff member?		
In your opinion, is the camper/staff member capable of carrying a full program in swimming and sports? If not, please explain:		
Signature of Physician:_____ Date:_____		