



Harbor Haven
470 Prospect Avenue, Suite 203B
West Orange, New Jersey 07052
Phone# 908-964-5411 Fax# 908-964-0511
E-mail: info@harborhaven.com
www.harborhaven.com
Medical Form

This page to be completed by parent or legal guardian. This entire form is required by State Law or child cannot attend.

Child's Name Last First MI Birth Date ___/___/___ Age ___ Sex ___
Who has legal custody of this child? _____

Parent/Guardian #1: Name _____ Home Address _____
Home# _____ Cell# _____ Work# _____

Parent/Guardian #2: Name _____ Home Address (if different) _____
Home# _____ Cell# _____ Work# _____

IN AN EMERGENCY NOTIFY: (Please list contacts that live a reasonable distance from Harbor Haven. Parents/Guardians will always be contacted first.)

Name _____ Name _____
Address _____ Address _____
City & State _____ City & State _____
Relationship _____ Relationship _____
Cell _____ Cell _____
Alternate Phone _____ Alternate Phone _____

Health History: (check-giving approximate dates)

Ear infections _____ Hay Fever _____ Mononucleosis _____ Mumps _____
Rheumatic Fever _____ Poison Ivy _____ Chicken Pox _____ Asthma _____
Convulsions _____ Insect Stings _____ Measles _____ Lyme Disease _____
Diabetes _____ Heart Disease _____ German Measles _____ Hepatitis _____
Seizure Disorder _____ Drug Allergy _____ Food Allergy _____ Other Allergy _____

Please describe any physical, mental or psychological conditions that require medication, treatment or special restrictions or considerations while at camp. _____

Operations or Serious injuries (dates) _____

Chronic or Recurring Illness _____

Seizures (if yes, please detail and provide seizure protocol) _____

Any specific activities to be encouraged? _____

Any specific activities to be restricted? _____

IMPORTANT: Please notify Harbor Haven if this child is exposed to any communicable diseases during the three weeks prior to starting the program.

Parent Authorization

Do you give permission for the following over-the-counter medications to be administered if needed, to your child at Harbor Haven. This may include Tylenol, Advil, Other [] YES [] NO (please list) _____
Do you give permission for Harbor Haven staff to apply sunscreen on your child if your child is unable to independently? [] YES [] NO
Do you give permission for routine healthcare services to be provided if needed to your child at Harbor Haven (i.e. first aid, temperature, etc.)? [] YES [] NO
In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the Harbor Haven director to hospitalize, secure proper treatment for and to order injection, anesthesia or surgery for my child as named above. [] YES [] NO
This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed Harbor Haven activities, except as noted by me and the examining physician
Signature _____ Date _____

List any health insurance coverage for the camper: Company _____ Policy or Group # _____
Company _____ Policy or Group # _____

(This page to be completed by a licensed physician) This form is required by State Law or child cannot attend.

Medical Examination

Child's Name: _____ DOB _____

Physician's Name: _____

Physician's Address _____

Physician's Phone _____ Physician's Fax: _____

Physician's Email: _____

This examination should be performed within 12 months of arrival at Harbor Haven. Examination for some other purpose with this time is acceptable. Examination is for determining fitness to engage in an active Harbor Haven program.

Date of exam _____

- Code: S – Satisfactory
- X – Not Satisfactory (explain)
- O – Not examined

Hgt: _____ Wt: _____ B.P. _____

Eyes _____

Glasses/Contacts _____

Ears _____

Nose _____

Throat _____

Teeth _____

Heart _____

Lungs _____

Abdomen _____

Hernia? Yes _____ No _____

Hgb. Test _____ Urinalysis _____

Extremities _____

Posture (spine) _____

Skin _____

Allergy _____

General Appraisal _____

Seizures? Yes _____ No _____

If yes, please describe below and attach seizure protocol, if applicable.

(for Girls and Women)

Has this person menstruated? _____

If not, has she been told about it? _____

If so, is her menstrual history normal? _____

Special Considerations _____

Recommendation and restrictions while enrolled in Harbor Haven

Special Diet _____

<u>Medication/Dosage</u>	<u>Reason</u>	<u>Will this medication be taken during the camp day?</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Swimming _____

Strenuous Activity _____

Other _____

I have examined the person herein and have reviewed his/her health history. It is my opinion that he/she is able to engage in Harbor Haven activities, except as noted above.

Examining Physician's Signature _____ Date _____

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This page to be completed by Physician's office or you may attach a copy of immunization record. This form is required by State Law or child cannot attend.

Child Immunization

Child's Name: _____ DOB: _____

VACCINE	DATE GIVEN
Diphtheria, Tetanus, Pertussis (if Td or DT please indicate*)	
LAST DATE OF TETANUS SHOT	
Polio Virus Vaccine	
Pneumococcal Vaccine	
Hepatitis B Vaccine	
Haemophilus B Vaccine	
Varicella (Chicken Pox Vaccine)	
Varicella	
MMR (Measles, Mumps, Rubella)	
MMR	
Other	
1	
2	
3	
4	
5	

* requires medical exemption

Provisional Admission Attached- date granted

Medical Exemption Attached

Religious Exemption Attached