Fill out one per family

2024 SUMMER CAMP MEDICAL RELEASE FORM

This form must be returned by May 31st

Child's Name: ____ Age: ______ Camp: _____________________________

Child's Name: ____ Age: ______ Camp: _____________________________

Child's Name: ____ Age: ______ Camp: _____________________________

Child's Name: ____ Age: ______ Camp: _____________________________

EMERGENCY CONTACT INFORMATION

Name of Parent/Guardian #1: ____

Where is the best place(s) to reach you? ☐ cell ☐ home ☐ work ☐ email ☐ text

Cell Phone #: ______________________________________ Home #: ____

Work Phone # ______________________________________ Email: ____

Name of Parent/Guardian #2: ____

Where is the best place(s) to reach you? ☐ cell ☐ home ☐ work ☐ email ☐ text

Cell Phone #: ______________________________________ Home #: ____

Work Phone # ______________________________________ Email: ____

Name of person picking up child: ____

(*If* ***other*** *than parent/guardian*) Relationship (e.g. Nanny)

Cell Phone #: ______________________________________ Home #: ____

Emergency Contact: ____

(*If* ***other*** *than parent/guardian*) Relationship (e.g. Nanny)

Cell Phone #: ______________________________________ Home #: ____

Work Phone # ______________________________________ Email: ____

Mail to: Spring Brook Country Club, 9 Spring Brook Road, Morristown, NJ 07960 (Attention: Martha)

or Fax to: 973-539-3809

This form must be returned by May 31st, 2024

Fill out one per Camper

MEDICATION AUTHORIZATION FORM

HEALTH HISTORY:

Camper's Name: ____ DOB: ____________ Camper's Group: _______________

(Please check all *those that apply.)*

□Asthma □ Allergies □ Diabetes □ Hearing or Vision Problems □ Wear Glasses □ Recent or Serious Injury or Illness □Chronic or Recurring Illness □ Other

Please explain below or attach note

____

____

____

Medications and Dosage

____

____

IMMUNIZATION HISTORY:

Vaccine / Oates:	Mo./Yr.	Mo./Yr.	Mo./Yr.	Mo./Yr.	Mo./Yr.	Mo./Yr.
DTaP:	_____	______	______	_______	______	______
HIB:	_____	______	______	_______	______	______
Pneumococ:	_____	______	______	_______	______	______
Polio:	_____	______	______	_______	______	______
Hep B:	_____	______	______	_______	______	______
MMR:	_____	______	______	_______	______	______
Varicella (Chicken Pox)	_____	______	______	_______	______	______

I have examined the above named Camper and found him/her to be free of communicable &
contagious disease. This camper has no physical, mental or other condition that may limit normal participation In camp activities except as above noted.

Signature: ____ Date: ______________________________

Physician/Nurse Practitioner:____ Date: _______________________

Address: ____Phone#: ________________________________

Mall To: SBCC, 9 Spring Brook Road, Morristown, NJ 07960 // racquets@springbrookcc.net

SUMMER CAMP ALERGY ACTION PLAN

This form must be returned by May 31st

Fill Out for Each Camper

Camper's Name ________________________________ **DOB** ______________ **Camp Group**______________

I/we parent(s) guardians understand that no medication will be administered to any camper - except the EpiPen supplied to the SBCC health director for the treatment of anaphylaxis due to allergy.

Parent/Guardian signature ____