

**BREENE'S CAMP RIVERBEND**

116 Hillcrest Road, Warren, NJ 07059-5328  
 Phone: (908) 580-CAMP Fax: (908) 647-2435  
 E-Mail: info@campriverbend.com • www.campriverbend.com

Group \_\_\_\_\_

Camper's Password: \_\_\_\_\_

Camper's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Mother's (Guardian's) Name: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Business Address: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Father's (Guardian's) Name: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Business Address: \_\_\_\_\_ Business Phone: \_\_\_\_\_

If parent's cannot be notified, please notify:

1) Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

2) Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Do you have any special recommendations for your child? (Include allergies, dietary restrictions, the need for earplugs, etc.)

Please provide any information about your child that would make his or her camp experience more enjoyable: (Please do **not** include grouping preferences here.) \_\_\_\_\_

May this child receive Tylenol:  Yes  No or Benedryl  Yes  No: If necessary during the camp session? Dosage will be adjusted per child's age.

**IN CASE OF MEDICAL EMERGENCY:** Every effort will be made to contact parents. In event I cannot be reached, I hereby give permission to the physician selected by the Camp Director to hospitalize and secure proper medical treatment for my child, named above. I hereby give the Camp Nurse permission to administer any medications prescribed by a physician to my child during the camp session. I authorize any physician, nurse or other health care provider to communicate with the medical staff and director of Camp Riverbend, or designee, about my child's medical condition, treatment, and/or prognosis. I further authorize Camp Riverbend's medical staff to discuss any medical conditions with the director, designee or my child's counselor(s) when the medical staff, in its sole discretion, believes such communication to be in the best interest of my child. This authorization is limited to June through August of this year.

**Signature Required** → Date: \_\_\_\_\_ Signature of Parent / Guardian: \_\_\_\_\_

**PHYSICIAN'S EXAMINATION**

VACCINE TYPE	1st Dose Mo/Day/Yr	2nd Dose Mo/Day/Yr	3rd Dose Mo/Day/Yr	4th Dose Mo/Day/Yr	5th Dose Mo/Day/Yr	LEAD SCREENING		
						Test Date	Result	
DIPHTHERIA, TETANUS, PERTUSSIS (DTaP) or any combination <i>* If TD or DT, indicate in corner box</i>								
Tdap								
POLIO – INACTIVATED POLIO VACCINE (IPV) <i>If oral vaccine, indicate (OPV) in corner box</i>								
MEASLES, MUMPS, RUBELLA (MMR)						<b>Document below single antigen vaccine receipt, serology titers, or varicella disease history</b>		
HAEMOPHILUS B (HIB)**								
HEPATITIS B						Hepatitis B	Date:	Titer:
VARICELLA						Varicella	Date:	Titer:
PNEUMOCOCCAL CONJUGATE**						Measles	Date:	Titer:
MENINGOCOCCAL						Mumps	Date:	Titer:
HEPATITIS A ***						Rubella	Date:	Titer:
HPV (HUMAN PAPILOMAVIRUS) ***								
OTHER								

Provisional Admission Attached – Date Granted \_\_\_\_\_  Medical Exemption Attached  Religious Exemption Attached

TB Screening (Mantoux Text)	Date			Chest X-Ray	Result		Therapy
	Date	Date	Date		Date	Normal	
Tested	_____	_____	_____	_____	_____	_____	Case <input type="checkbox"/> Reactor <input type="checkbox"/>
Read	_____	_____	_____	_____	_____	_____	Date Started _____
Result (MM)	_____	_____	_____	_____	_____	_____	Date Completed _____

\* REQUIRED MEDICAL EXEMPTION \*\* REQUIRED FOR DAY/CHILDCARE ENROLLEES (2 Months-5th Birthday only) \*\*\* NOT REQUIRED

General condition of health: \_\_\_\_\_

Allergies: \_\_\_\_\_

Limits or restrictions: \_\_\_\_\_

Does the child have a history of any chronic or recurring illnesses? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, what is the nature of the illness? \_\_\_\_\_

Does the child take any prescribed medications regularly? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, what is the name of the medication prescribed, dosage, and time of administration?

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Time: \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Doctor's Name (Print) \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Date \_\_\_\_\_