



Commonwealth-Parkville School

COMETS SUMMER CAMP

Att. Physical Education Department

Tel. 787-720-3992 / Fax 787-789-2305

www.cpspr.org



CAMPER HEALTH HISTORY FORM

(This form is to be completed by parents/guardians of minor)

Camper Name _____ Age _____ Date of Birth _____

General Questions (Explain "yes" answers)

Has/ Does the camper:	Yes	No	Explain
1. Had any recent injury, illness or infectious disease?			
2. Has a disability or chronic or recurring illness?			
3. Have frequent headaches?			
4. Have diabetes?			
5. Have asthma?			
6. Have allergies?			
7. Ever had frequent ear infection?			
8. Have history of convulsions?			
9. Ever had problems with joint (E.g. knees & ankles)?			
10. Ever had back problems?			
11. Ever had high blood pressure?			
12. Has a dietary modification?			
13. Has a restriction in physical activities?			
14. Has other disease?			

Please list ALL medications the child takes routinely and reasons for taking them _____

Name of dentist / orthodontist _____ Phone _____

Name of family physician _____ Phone _____

Do you carry family medical / hospital insurance? Yes _____ No _____

If so, indicate: Carrier _____ Policy or Group # _____

Name of insured _____ Relationship to participant _____

Is there any additional information about the camper's behavior and physical, emotional, or mental health which the camp should be aware of? _____

IMPORTANT

IMMUNIZATION HISTORY MUST BE UPDATED, PLEASE BRING A COPY OF THIS RECORD AT THE TIME OF REGISTRATION

In case of emergency, I authorize Commonwealth-Parkville School, Inc. staff, directors, teachers, and athletic supervisors to exercise their best judgment as to treatment needed and facilities to use. I further grant the staff of the hospital my full permission to perform any treatment they judge necessary to ensure the welfare and the wellbeing of my child on such occasion. This permission is granted even though I, or other legal guardians of my child are not present or cannot be contacted at the time such emergency treatment is needed.

I grant my child permission to take **Tylenol** or its generic equivalent YES _____ NO _____ **Benadryl** or its generic equivalent YES _____ NO _____ in the event he/she should need it during camp hours.

Signature of parents or guardian _____ Date: _____

Revised



Commonwealth-Parkville School

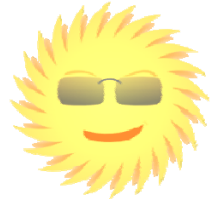
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PHYSICAL EXAMINATION

(Should be completed by child's physician)



Camper Name _____ Age _____ Date of Birth _____

Weight _____ Height _____ Blood Pressure _____

1. Observable evidence of illness, injury, disability or communicable disease _____
2. Current medical treatment required at camp _____
3. Record of medication brought to camp _____
4. Any medical prescribed meal plan or dietary restrictions _____
5. Description of any limitations or restriction on camp activities _____
6. Additional information for health care staff at the camp _____

Which of the following has the camper had? (Check. Give approximate dates.)

- _____ Measles
- _____ Chicken Pox
- _____ German measles
- _____ Mumps
- _____ Hepatitis
- _____ Convulsions
- _____ Heart Defect/Disease
- _____ Diabetes
- _____ Bleeding/Clotting Disorder
- _____ Hypertension
- _____ Asthma
- _____ Others (Specify) _____
- _____ Allergies
- _____ Hay Fever
- _____ Ivy Poisoning, etc
- _____ Insect Stings
- _____ Penicillin
- _____ Other Drugs
- _____ Other (Specify), _____

I certify that _____ is able to participate in an active camp program.

Physician Name _____ Date of examination _____

Address _____ Phone _____

Lic. No. _____ Signature _____

***IMPORTANT* IMMUNIZATION HISTORY MUST BE UPDATED**



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Calle Alabama Final Urb. Parkville

Guaynabo, PR 00969

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PICK-UP AND DROP OFF RELEASE FORM

I _____ parent/ guardian of _____
camper (s), give complete permission to the following persons to pick up and drop off my child (ren)
at Comets Summer Camp.

Name	Relation
1.	
2.	
3.	
4.	

*Comets
Summer
Camp*