



The Department of Health requires the following information to be on file at camp. Please complete this (or have your physician complete it) and mail to:

Squire Camps
 P.O. Box 885
 Sleepy Hollow, NY 10591
 Winter Phone: (914) 328-3798

Camper's Name: _____ Birth Date: _____

Address: _____

Telephone Home: _____

Mother Telephone Business: _____

Father Telephone Business: _____

Cell number: _____ E-mail Address: _____

IN CASE OF EMERGENCY NOTIFY:

NAME	RELATION TO CAMPER	PHONE

Name of Physician _____ Phone Number _____

Date of Last Physical Examination _____

Are there any allergic problems? _____

Is medication regularly taken? _____

Is a special diet required? _____

Are there any conditions that require special attention at camp? _____

IMMUNIZATION RECORD *(include all dates)*

Vaccine	1st	2nd	3rd	Booster	Booster
DTP	1st	2nd	3rd	Booster	Booster
Polio	1st	2nd	3rd	Booster	Booster
Hep B	1st	2nd	3rd		
MMR	1st	2nd			
VAR	1st				
HIB	1st	2nd	3rd	4th	
Tuberculin Test		Type	Date	Result	

I understand that in case of emergency, I will be contacted first. If I, or the other emergency contacts cannot be reached, I grant permission for my child to be given medical treatment as prescribed by a physician or hospital.

Parent's signature _____