2023 MEDICAL INFORMATION

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)*

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	

PLEASE ATTACH PHYSICIANS IMMUNIZATION RECORDS TO THIS FORM

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_____