**2025 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_____