426 Case Blvd. Flemington, NJ 08822
Phone: 908.237.1423 Fax: 908.237.2423

NAME OF CHILD (LAST, FIRST, MI)	DATE OF BIRTH (Mo./Day/Yr.)	SEX ☐ M ☐ F
PARENT (S) / GUARDIAN(S) NAME(S)	HOME PHONE NUMBER	
STREET ADDRESS	NAME OF DOCTOR	
CITY, STATE, ZIP CODE	DOCTOR'S TELEPHONE NUMBER	

PHYSICAL EXAMINATION

Ht.	Wt.	Heart	Lungs	ENT	Extreme.	Other

☐ Child is found to be healthy and normal and may participate in all Camp activities.

☐ Child has the following areas of concern ____
which will / will not affect participation as follows____
Comments ____

HEALTH HISTORY

Previous Communicable Diseases and Dates

Other Illnesses, Accidents or Operations and Dates

Existing Allergies or Chronic Conditions

Medications

Special Needs, Individual Limitations

Previous Screenings, Evaluations, Dates and Results

IMMUNIZATION RECORD

VACCINE TYPE	DISEASE MO/DAY/YR	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	MO/DAY/YR
DIPHTHERIA, TETANUS. PERTUSSIS (DTP) (If Td, DtaP, or DT, indicate in corner box)							
POLIO- INACTIVATED POLIO VACCINE (IPV) (If oral vaccine, indicate OPV in corner box							
MEASELS, MUMPS, RUBELLA(MMR)							
MEASLES					Measles Serology	DATE:	TITER:
RUBELLA					Rubella Serology	DATE:	TITER:
MUMPS					Mumps Serology	DATE:	TITER:
HAEMOPHILUS B (HIB)							
HEPATITIS B					Hepatitis B Serology	DATE:	TITER:
VARICELLA					Vericella Serology	DATE:	TITER:
OTHER, SPECIFY							

Physician Signature Date

MEDICAL PERMISSION FORM & INDIVIDUAL MEDICATION RECORD

Child's Name ____

Condition ____

Special Instructions or Concerns____

____

____

Medication ____

Prescription ___________ Non Prescription ____________

Amount to be Administered____

Frequency of Medication ____

Refrigeration Required Yes _________ No _________

Possible Adverse Reaction(s)

____

____

Physician Signature (Necessary for prescription medication only)

____

Date ______________________

Parent/Guardian Signature ____

Date ______________________

Staff member authorized to administer medication

Name ____

Signature ____

Date ______________________

CAMP NATION/Aspen Ice at Flemington LLC, WAIVER/RELEASE OF LIABILITY

PLEASE READ CAREFULLY BEFORE SIGNING. THIS IS A RELEASE OF LIABILITY AND WAIVER OF CERTAIN RIGHTS.

I, ____, the Parent and/or Guardian of ____, the enrolled participant of CAMP NATION (Aspen Ice at Flemington LLC) understand that various daily activities to include but not limited to ice skating, gymnastics, wall climbing, baseball/softball, soccer, basketball, volleyball, & swimming are daily activities of the camp, and that each could be considered HAZARDOUS activities. I also recognize that there are risks inherent in each of these activities.

The enrolled participant's parent/guardian hereby agrees to indemnify and hold harmless Camp Nation (Aspen Ice at Flemington LLC,) its coaches, officers, directors, agents and employees against any liability resulting from injuries that may occur to the participant during ordinary daily camp activities. The parent/guardian of the participant also agrees to indemnify Camp Nation (Aspen Ice at Flemington LLC) for any damages incurred arising from any claims, demands, action or cause of action by the participant.

The parent/guardian of the participant authorizes any representative of Camp Nation (Aspen Ice at Flemington LLC) to have the participant treated in any medical emergency during their participation in said activities. Further the parent/guardian agrees to pay all costs associated with medical care and transportation of the participant.

Any medical or health problems have been disclosed to Camp Nation (Aspen Ice at Flemington LLC).

I HAVE CAREFULLY READ THE ABOVE LIABILITY RELEASE AND SIGN IT WITH FULL KNOWLEDGE OF ITS CONTENT AND SIGNIFICANCE.

Parent and/or Guardian Signature ____

Date __________________________________

EMERGENCY FORM

Child's Name____ Birth Date ______________________

Allergies/Medical Problems ____

____

Mother /Father/ Guardian Names ____

Home Address_______________________________________ Home Phone#______________________

Mother Work #_______________________________ Cell #______________________________

Father Work #_______________________________ Cell #______________________________

Emergency Contacts (other than mother, father, or guardian)

Name	Address	Phone #'s	Relationship
1.____________________	_______________________	___________________	______________
	_______________________	___________________	
2.____________________	_______________________	___________________	______________
	_______________________	___________________	
3.____________________	_______________________	___________________	______________
	_______________________	___________________	

AUTHORIZATION FOR PEDIATRIC/EMERGENCY/MEDICAL/SURGICAL TREATMENT

It is the firm hope that the authorization granted in this form will never be needed. For the safety of the children, however, sound medical practice calls for such authorization. The authorization granted by this form will be used only when absolutely necessary.

I authorize Camp Nation (Aspen Ice at Flemington LLC) to call an emergency ambulance or vehicle in case of accident or acute illness (the determination thereof shall rest solely with Camp Nation (Aspen Ice at Flemington LLC). In case of emergency requiring medical attention, I hereby give permission to have my child, __________________________ taken to __________________________________ (Hospital choice) or other nearby medical facility for medical care under __________________________________ (Doctor Choice) or other qualified physician.

Family Insurance Company____
Insurance Company Address__________________________________ Policy #_____________________

I authorize Camp Nation (Aspen Ice at Flemington LLC) to take a temperature reading if necessary, I understand that ear or under arm reading only will be taken.

Parent Signature____ Date___________________

Camp Nation

Permission Forms
Sunscreen Application and Daily Pick up

My child____

Circle One: **Will** **Will Not** be using sunscreen (which I have provided and labeled with my child's name) during the times that we are outdoors.

During these times I give permission for the sunscreen to be applied by:

Circle One: **My child to him/her self** **A counselor**. **Either**

***Please use this section to give permission for additional individuals to pick up your child or children at the end of the day. List any persons that will be picking up your child and the days they will be picking up so as to avoid confusion when carpooling.**

My child is in the custody of ☐ mother ☐ father ☐ both parents ☐ other (see below)

Pick up will be done primarily by ☐ mother ☐ father ☐ both parents ☐ other (see below)

The following people have my permission to pick up my children from Camp.

Name & Phone Number	Relationship	Date of Pick up
1.______________________	____________________	______________
______________________		
2.______________________	____________________	______________
______________________		
3.______________________	____________________	______________
______________________		
4.______________________	____________________	______________
______________________		
5.______________________	____________________	______________
______________________		

____ ____________________
Signature of Parent or Guardian Date