



the institute for the musical arts Rock 'n' Roll camp for girls

P.O. box 867 - Goshen, Ma. 01032 Phone:(413)268-3074 Email: info@ima.org

IMA Rock 'n' Roll Girls Camp Primary Information and Health form

Information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care. (this side to be filled out by parent/guardian of minors or by campers/staff members themselves.)

Name _____ birthdate _____ Age _____
Last Name First Name Middle Initial

Parent or Guardian Name _____

Home Address _____ Phone _____
Street & Number City State Zip Code Area/number

Business _____ Phone _____
Street & Number City State Zip Code Area/number

Second Parent or Guardian or Emergency Contact Name _____

Home Address _____ Phone _____
Street & Number City State Zip Code Area/number

If not available in an emergency, notify Name _____

Address _____ Phone _____
Street & Number City State Zip Code Area/number

Health History

(check, give approximate dates.)

- Frequent Ear infections
- Heart Defect/Disease
- Convulsions
- Diabetes
- Bleeding/Clotting Disorders
- Hypertension
- Mononucleosis

Diseases

- Chicken Pox
- Measles
- German Measles
- Mumps

Allergies *(dates not needed)*

- Hay Fever
- Ivy Poisoning, etc.
- Insect Stings
- Penicillin
- Other Drugs
- Asthma
- Other *(Specify)*

Operations or serious injuries (dates) _____

Chronic or recurring illness or medical condition _____

Dietary restrictions _____

Current medications **(send with instructions)** _____

Other diseases _____

Name of dentist/orthodontist _____ Phone _____

Name of family physician _____ Phone _____

Do you carry medical/hospital insurance? yes no

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

Has the minor menstruated? _____

If no, has she been told about it? _____

If so, is her menstrual history normal? _____

Special considerations/Suggestions on health related information for camp Personnel

Important-This Box Must Be Completed For Attendance*

Guardian Authorization (required for persons 18 years of age and under) The person herein described has permission to engage in all Camp activities, many of which are conducted in outdoor environments, except as noted by the examining physician and me. I hereby give permission to the medical personnel selected by the camp director to provide routine health care; administer certain over-the-counter medications when necessary and necessary related transportation for me/or my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for the person named below. I will make sure she will not attend if not feeling well or exposed to a communicable disease. On camp arrival day, the camp medical personnel have the right to refuse to admit a person to the camp who does not meet acceptable health conditions e.g. temperature, contagious disease, etc. She has had no serious illness or operation since this doctor's examination. This completed form may be photocopied for trips out of camp. The reproduction of images taken of my child may be used for Camp publicity purposes. My child has my permission to take any out of camp trips.

Signature of Parent/Guardian or adult camper/staffer _____

Witness _____ Date _____

I also understand and agree with the restrictions placed on my camp activities

Signature of minor _____



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Immunization History

Required immunizations must meet Massachusetts standards. Please record the date (month and year) of the basic immunizations and most recent booster doses.

Vaccines	Year of Basic Immunization	Year of Last Booster
Diphtheria Pertussis(Whooping Cough) DPT Tetanus	1. 2. 3.	1. 2.
or		
Tetanus Diphtheria TD or		
Tetanus		
Oral Polio (Sabin)* TOPV		
Injectable Polio (Salk)		
Measles (hard measles, red measles, Rubeola)		
Mumps		
Rubella (German measles, 3-day measles)		
Other		
Tuberculin test given _____ (most recent)		
Haemophilus influenza b (HIB)		
Hepatitis B		

Health Care Recommendations by a Licensed Physician

I have examined the above applicant within the past 12 months. Date examined _____

In my opinion, the above's condition __does __does not preclude her participation in an active camp program.

Height _____ Weight _____ Blood Pressure _____

The applicant is under the care of a physician for the following condition(s) _____

Current treatment (include current medications) _____

Explanation of any reported loss of consciousness, convulsion, or concussion _____

Does applicant have epilepsy? __yes __no Does applicant have diabetes? __yes __no

Recommendations and restrictions while at IMA Rock n Roll Camp for Girls

Any treatment to be continued at camp _____

Any medication to be administered at camp (specific dosages) _____

Any medically prescribed meal plan or dietary restrictions _____

Any allergies (food, drugs, plants, insects, etc.) _____

Activities to be encouraged or limited _____

Additional Health Information _____

Licensed Physician's Signature _____

Address _____ Phone _____
Street & Number City State Zip Code Area/Number

Date of Form Completion _____ *by _____
Must be within 2 months of going to camp *Initial if completed by nurse or physicians assistant