# LML COMPASS CAMP

### MEDICAL HISTORY

Failure to return or complete information may

delay your camp registration.

To the Parents of Campers:	Please complete this form carefully. All health records are confidential.	Information supplied will become a part of your child's health record.
Camper's Name: (Last)	(First)	(MI) (Preferred)
Street Address:		
City:	State:	Zip:
Home Phone:	SS#:	Sex:
Date of Birth:	Height:	Weight:
Name of Family Physician:		Phone:
	<b>REPORT OF MED</b>	ICAL HISTORY
Does your child have any allergi	es? Yes No	If yes, specify:
Aspirin Penicillin	Codeine Bee Stings	Molds/Fungi
Eggs Sulfa	Tetanus Toxoid Other	·

Has your child ever had any of the following? Comment below on all "Yes" answers.

YES	NO		YES	NO		YES	NO		YES	NO	
		Measles (Red)			Hay Fever/Asthma			Chest Pain / Pressure			Jaundice
		German Measles			DES Exposure			Chronic cough			Mononucleosis
		Mumps			Appendectomy			Palpitation (Heart)			Gallbladder Trouble
		Chicken Pox			Tonsillectomy			Rheumatic Fever			Stomach Ulcers
		Malaria			Hernia repair			High Blood Pressure			Recurrent Diarrhea
		Anemia			Other Surgery (Note Below)			Heart Murmur			Recent Weight Gain
		Gum / Tooth Trouble			Insomnia			Heart Disease			Venereal Disease
		Sinusitis			Recurrent Headache			Joint Disease			Dizziness, Fainting
		Eye Problems			Recurrent Bladder Infection			Arthritis			Weakness, Paralysis
		Ear Problems			Kidney Disease			Back Problems			Diabetes
		Recurrent Colds			Head Injury/Unconsciousness			Seizure/Convulsions			Recent Weight Loss
		Tumor, Cancer, Cyst			Shortness of Breath			Tuberculosis			Hypoglycemia

Remarks or additional information on all "YES" answers, drug allergies, and any other infectious diseases not listed.

Please list all medications ye	our child is currently taking.
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Is your child presently under treatment for any physical or emotional problem?

YES NO Diagnosis:

#### Parental Statement and Consent / Liability Waiver

I hereby certify that the medical history I have provided is accurate and complete to the best of my knowledge. In the event that I or my authorized physician cannot be reached in an EMERGENCY, and immediate observation or treatment is urgent in the judgement of the Camp Director, I hereby grant permission for the LML Compass Camp staff to arrange for transport of my child to a local hospital for treatment if such transport is deemed by them in the best interest of my child's welfare.

I / we, the undersigned, for ourselves, our heirs, executors and administrators, waive and release any and all rights and claims for damages I may have against the LML Compass Camp or Compass Academy Charter School and its respective agents, representatives successors and assignees, for any and all injuries which may be suffered by my child in connection with the LML Compass Camp program. Furthermore, I attest and verify that I have full knowledge of the risks associated with an activities camp of this nature. I also understand that responsible care will be exercised in the supervision of these activities.

Custodial Parent or Guardian	Phone	Date
Custodial Parent or Guardian	Phone	Date
	Thone	Date

If unable to reach the above signed, in case of an emergency please contact:

Name

Phone

Relationship

# Please Return Health Form with a copy of each child's current immunization records to:

## LML Compass Camp

23 West Chestnut Ave Vineland, NJ 08360 Phone (856) 899-5570 Fax (856) 431-7941