Pennypacker Swim and Tennis Club

Summer Day Camp

Registration Form

Parents Name: _____

Street: _____ City: _____

Zip: _____ E-mail: _____

Home phone number: _____

Mother's Cell phone number: _____ Mother's Work phone number: _____

Father's Cell phone number: _____ Father's Work phone number: _____

Children: List each child below

Name	Date of birth	Age	Boy or Girl

Session Name	Date	Amount	Times	Number Attending
☐ Week 1	June 21 – 25	$375	9:00 am – 4:00 pm	_____
☐ Week 2	June 28 – July 2	$375	9:00 am – 4:00 pm	_____
☐ Week 3	July 6 – July 9 (4 days)	$300	9:00 am – 4:00 pm	_____
☐ Week 4	July 12 – July 16	$375	9:00 am – 4:00 pm	_____
☐ Week 5	July 19 – July 23	$375	9:00 am – 4:00 pm	_____

☐ Check this box if extended time is needed ($100 additional). Specify the weeks of extended time below (circle)

June 21 – 25 June 28 – July 2 July 6 – 9 ($80.00) July 13 – 17 July 19 – July 23

Total Amount enclosed: _____

Please mail completed form to Pennypacker C.C., 256 Eagleview Blvd., P.O. Box 370, Exton, PA 19341, Make Check payable to Pennypacker Country Club Treasurer

I accept full responsibility for any injury to my son or daughter during the Pennypacker Camp activities. Every effort is made to protect the health and safety of the participants, but my child is insured and, in the event of my child's injury, I shall not hold responsible Pennypacker Country Club or any member of the Pennypacker Country Club staff or business partners.

Signature of Parent or Guardian: _____ Date: _____

Pennypacker Country Club may use photos of campers for promotional purposes in publications and on the website. No identification of such campers shall be made.

Signature of Parent or Guardian: _____ Date: _____

If there are allergies or any other important information that the camp counselors should know, please let the office know prior to camp starting. A health history form is required for each camper before the end of June (see website for form).

Health History Form

Pennypacker Summer Day Camp

Camper Information Camper's Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Age: _____ Gender: M or F School: _____

Parent / Guardian Information

Parent/Guardian #1: _____ Address (if different from child) _____

Phone 1: _____ Phone 2: _____ E-mail: _____

Parent/Guardian #2: _____ Address (if different from child) _____

Phone 1: _____ Phone 2: _____ E-mail: _____

Emergency Contacts

Name: _____ Relationship: _____ Phone 1: _____ Phone 2: _____

Name: _____ Relationship: _____ Phone 1: _____ Phone 2: _____

Medical History Information

Health Information (Check all that apply and provide requested information)

Allergies	Yes	No	Explain "yes" answers. Include the type of allergy (e.g.- "nut allergy" in the food category)
Animals			
Insect Stings			
Plants / Trees			
Food			
Drugs			
Other			

Diet / Nutrition:

- ☐ This camper eats a regular diet
- ☐ This camper eats a regular vegetarian diet
- ☐ This camper has special food needs (Please describe dietary needs below)

Immunization History:

Are all immunizations current? Yes No

If not, state reason(s):

DTP or DT (Tetanus) Date:

☑	Condition	Dates	☑	Condition	Dates	☑	Condition	Dates
	ADD/ADHD			Epilepsy			Muscle Disease/Disorder	
	Arthritis			Fainting			Nervous System Disorder	
	Asthma			German Measles			Sickle Cell Anemia	
	Athletes Feet			Hay Fever			Sinusitis	
	Bed Wetting			Headaches/Migraines			Skeletal Disease/Disorder	
	Bleeding/Clotting disorder			Hearing			Skin Conditions	
	Bronchitis			Heart Defect/Disease			Sleep Disturbance/Walking	
	Chicken Pox			Hypertension			Stomach Upsets	
	Colds/Sore Throats			Kidney Disease			Urinary Tract Infections	
	Constipation			Measles			Wear: Contacts Glasses	
	Convulsions			Mononucleosis			Other:	
	Diabetes			Motion Sickness			Other:	
	Ear Infections			Mumps			Other:	

General Health History: Check yes or no for each statement. Explain 'yes' answers below.

1. Ever been hospitalized? □Yes □No
2. Ever had surgery? □Yes □No
3. Have recurrent/chronic illness? □Yes □No
4. Had a recent infectious disease? □Yes □No
5. Had a recent injury? □Yes □No
6. Had asthma/wheezing/shortness of breath? □Yes □No
7. Have diabetes? □Yes □No
8. Had seizures? □Yes □No
9. Had headaches? □Yes □No
10. Wear glasses, contacts or protective eyewear? □Yes □No
11. Had fainting of dizziness? □Yes □No
12. Passed out/had chest pain during exercise? □Yes □No
13. Had mononucleosis ("mono") during the past 12 months?□Yes □No
14. If female, have problems with periods/menstruation? □Yes □No
15. Ever had back/joint problems? □Yes □No
16. Have problems with diarrhea/constipation? □Yes □No
17. Have any skin problems? □Yes □No
18. Traveled outside the country in the past 9 months? □Yes □No

Please explain all "yes" answers in the space below, noting the number of questions. For the travel outside the country, please name countries visited and dates of travel.

Explain any specific needs or accommodations required: _____

Explain any known behavioral and/or emotional problems: _____

Explain any psychiatric counseling or hospitalization: _____

Explain any operations or serious injuries: _____

Explain any disabilities or chronic or recurring illnesses: _____

Explain any activities that are discouraged or limited by your child's physician: _____

Has menstruation begun? Yes No If not, does she know what it is? Yes No If yes, is her menstrual history normal? Yes No

MEDICATION INFORMATION

Are any prescription medications being taken? Yes No Are any of the following used? Inhaler EpiPen

Medications: **Below list all current medications including prescribed and over-the-counter drugs taken.**

Medicine #1: _____ Dosage: _____ Time Taken daily: _____

Medicine #2: _____ Dosage: _____ Time Taken daily: _____

Medicine #3: _____ Dosage: _____ Time Taken daily: _____

Medicine #4: _____ Dosage: _____ Time Taken daily: _____

My child may be given (circle each product): Aspirin Benadryl Ibuprofen Neosporin Tylenol None

Medical Care and Insurance Information

Physician:_____ Phone: _____

Dentist/Orthodontist:_____ Phone: _____

Preferred Medical Facility: _____ Address: _____

Insurance Company: _____ Policy #: _____

Policy Holder: _____Company Address: _____

AUTHORIZATION FOR MEDICAL CARE

This health history is correct so far as I know. The person herein described has permission to engage in all activities except as noted. I hereby give permission to the First-Aider or Adult-In-Charge to provide routine health care and witness prescribed medications. I consent for my child to receive such medical treatment and/or surgical procedures as are deemed necessary in the event of an emergency and to assume liability for any medical expenses involved. This authorization extends to my child's participation in any activity sponsored by Pennypacker Country Club. Should a medical emergency arise during my child's participation in Pennypacker Summer Day Camp, I understand that reasonable efforts will be made to contact me or my designated alternate at the phone numbers I have given. If it is believed my child's life or health may be adversely affected by the delay that an attempt to contact me or my designated alternate would cause, I consent to the administration of medical treatment and/or surgical procedure deemed necessary by the medical doctor and/or medical facility and the immediate administration of life-sustaining measures deemed necessary under the circumstances. This completed form may be photocopied.

Signature: _____ Date: _____

* If for any reason you cannot sign this form, attach a written statement to this form. The statement must be signed for attendance/participation.