South Plainfield Legends Camp Forms 2025

Participant Name: _____DOB: _____/_____/_____

Address: _____

Parent/Guardian Contact Information:

Name: _____

Phone: _____Alternate Phone: _____

Name: _____

Phone: _____Alternate Phone: _____

Emergency Contact Information:
(Please provide the name of a relative or friend other than a parent that can assume responsibility for the care of your child in an emergency. These people will also be authorized to pick up your child.)

Name: _____Relationship: _____

Phone: _____Alternate Phone: _____

Name: _____Relationship: _____

Phone: _____Alternate Phone: _____

Name: _____Relationship: _____

Phone: _____Alternate Phone: _____

If there are any legal issues, we should be aware of, please provide us with an updated court document stating such. We will abide by legal documents only when dealing with children and custody issues. Otherwise, either parent has equal rights to their child(ren) and their information regarding them such as invoices, medical records, and camp schedules. If you have any additional questions, please speak to the Camp Director directly.

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Participant Name: _____DOB: _____/_____/_____

Medical Information:

Family Doctor: _____Phone: _____

Immunization History: (Fill out the chart or provide a copy of immunization records.)

Immunization	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Most Recent Dose
Diptheria, tetanus, pertussis						
Tetanus booster						
Mumps, Measles, Rubella						
Polio						
Haemophilus Influenzae Type B						
Pneumococcal						
Hepatitis B						
Hepatitis A						
Chicken Pox/ Had Chicken Pox Date						
Meningococcoccal Meningitis						

If your campers has NOT been fully immunized, please sign the following statement. I understand and accept the risks to my child from not being fully immunized.

Signature of Custodial Parent/Guardians: _____Date: _____

Has/does the camper:	YES	NO	EXPLAIN "YES" Answers
Ever been hospitalized?			
Ever had eye surgery?			
Have a recurrent/chronic illness?			
Had a recent infectious disease?			
Had a recent injury?			
Had asthma/wheezing/shortness of breath?			
Have diabetes?			
Had seizures?			
Had headaches?			
Wear glasses, contacts, or protective eyewear?			
Wear dental appliance? (retainer, braces, etc)			
Had fainting or dizziness?			
Passed out/had chest pain during exercise?			
Had mononucleosis during the past 12 months?			
Have problems falling asleep/sleepwalking?			
Ever had back/joint problems?			
Have a history of bedwetting?			
Have problems with diarrhea/constipation?			
Have any skin problems?			
If female, have problems with periods/menstruation?			
Traveled outside the country in the past 9 months? (IF yes, note countries & dates traveled)			
OTHER:			

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Participant Name: _____DOB: _____/_____/_____

Allergies:

☐ No known allergies ☐ This camper is allergic to: ☐ Food ☐ Medicine ☐ The Environment (insect stings, hay fever, etc)

☐ Other **(Please describe below what camper is allergic to and the reaction seen.)**

Diet/Nutrition:

☐ This camper eats a regular diet. ☐ This camper eats a regular VEGETARIAN diet.

☐ This camper has special food needs. **(Please describe below)**

Restrictions:

☐ I have reviewed the program and activities of the camp and feel the camper can participate without restrictions.

☐ I have reviewed the program and activities of the camp and feel the camper can participate with the following restrictions or adaptations. **(Please describe below)**

Medications:

☐ This camper will NOT take any daily medications while attending camp.

☐ *This camper WILL take the following medication(s) while at camp: **(Please describe below)**

*If you will be sending your child to camp with medication the health director will administer, you must provide a **Treatment Plan that has been signed by your doctor**. Two of the more common Action Plans are Asthma Treatment Plan and Allergy and Anaphylaxis Treatment Plan. We cannot administer medication to your child without an Action Plan signed by a doctor. You can either upload the paperwork to Community Pass or you can provide a hard copy when you drop off your child's medication to the health director.

What Else Should We Know:

Please provide any additional information about the camper's health that you think important or that may affect the camper's ability to fully participate in the camp program. (Attach additional information, if needed)

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Permission to Treat

In consideration of my child's participation in the South Plainfield Legends Camp to take place during the period 6/23/2025- 8/29/2025 at the South Plainfield PAL building, I have read and understand the following:

- I give my consent for the camp health director or any of the trained staff to treat my child _____, for minor injuries which include but are not limited to, scrapes, contusions, lacerations, and normal bumps and bruises. For these minor injuries that are treated on site, I will be notified at pick-up at the end of the day.
- Over the Counter Medications provided by the parent/guardian may be administered following the directions provided. All over-the-counter medications must be in their original container and be accompanied by a notice (provided by the camp when dropping off) explaining parents' expectations for providing to your camper.
- I understand that I will be notified immediately of any serious injury such as loss of consciousness, severe bleeding, an allergic reaction, broken bones, head trauma, or any other injury the health director warrants as an emergency.
- I give my consent, in an emergency, to arrange for transportation to a hospital. I understand an adult camp representative will escort my child and stay with them until a parent/guardian arrives.

Print Name of Parent/Guardian Completing this FORM: _____

Parent/Guardian Signature: _____Date: _____