# APPLE Seedlings Day Camp Profile Form

Camper Name:_____
Last First Middle

Address:_____
Street City, State Zip

Parent/Guardian Names:_____

Home Phone:_____ Cell Phone:_____

Emergency Contact (In case we can reach a parent):_____
Name Phone Number

Other than parents, individuals who may pick up your child from camp:_____

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Date of birth:_____ Grade Entering:_____

Nickname:_____

Is your child: (Outgoing) (Quiet and Shy in Groups)

Concerns we should be aware of including allergies:_____

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Do we have permission to take pictures of your child for possible craft projects or bulletin boards/APPLE Seeds use? ( YES) (NO)

Permission: (This section must be signed in order for your child to attend camp)

_____HAS MY PERMISSION TO ATTEND THE APPLE SEEDLINGS CAMP.

_____ _____
Parent/Guardian Signature Please print name here

Date:_____

12/99

# Children's Medical Report

Name of Child _____ Birthdate _____

Name of Parent or Guardian _____

Address of Parent of Guardian _____

**A. Medical History** (May be completed by parent)

1. Is child allergic to anything? No___ Yes___ If yes, what? _____

2. Is child currently under a doctor's care? No___ Yes___ If yes, for what reason? _____

3. Is the child on any continuous medication? No___ Yes___ If yes, what? _____

4. Any previous hospitalizations or operations? No___ Yes___ If yes, when and for what? _____

5. Any history of significant previous diseases or recurrent illness? No___ Yes___;
   diabetes No___ Yes___; convulsions No___ Yes___; heart trouble No___ Yes___.
   If others, what/when? _____

6. Does the child have any physical disabilities: No___ Yes___ If yes, please describe: _____

Any mental disabilities? No___ Yes___ If yes, please describe: _____

**Signature of Parent or Guardian** _____ **Date** _____

**B. Physical Examination:** This examination must be completed and signed by a licensed physician, his authorized agent currently approved by the N. C. Board of Medical Examiners (or a comparable board from bordering states), a certified nurse practitioner, or a public health nurse meeting DEHNR standards for EPSDT program.

Height _____% Weight _____%

Head _____ Eyes _____ Ears _____ Nose _____ Teeth _____

Throat _____ Neck _____ Heart _____ Chest _____ Abd/GU _____

Ext _____ Neurological System _____ Skin _____

Results of Tuberculin Test, if given: Type _____ date _____ Normal ___ Abnormal _____
Should activities be limited? No___ Yes___ If yes, explain: _____
Any other recommendations: _____

_____ Date of
_____ Examination _____

**Signature of authorized examiner/title** _____ **Phone #** _____

Please attach a copy of the student's immunization history.