CORA HARTSHORN ARBORETUM & BIRD SANCTUARY

324 Forest Drive South, Short Hills, NJ 07078
P: 973.376.3587 F: 973.379.5059
www.hartshornarboretum.org

HEALTH AND EMERGENCY FORM

Participant's Name: _____ _____ _____
First Middle Initial Last

□ Male □ Female Birth Date: _____ Age: _____ Grade: _____
(Month/Day/Year)

Participant's Address: _____
Street Address City State Zip Code

PARENT/GUARDIAN TO BE CONTACTED IN CASE OF ILLNESS OR INJURY:

Name: _____ Relationship: _____

Primary Phone: (_____) _____ Secondary Phone: (_____) _____

Home Address: _____
(If different from above) Street Address City State Zip Code

E-mail Address: _____

SECOND PARENT/GUARDIAN OR OTHER EMERGENCY CONTACT:

Name: _____ Relationship: _____

Primary Phone: (_____) _____ Secondary Phone: (_____) _____

ADDITIONAL CONTACT IN EVENT PARENT(S)/GUARDIAN(S) CANNOT BE REACHED:

Name: _____ Relationship: _____

Primary Phone: (_____) _____ Secondary Phone: (_____) _____

THE FOLLOWING INDIVIDUALS ARE AUTHORIZED TO PICK-UP MY CHILD FROM ARBORETUM PROGRAMS:

Full Name(s): _____, _____, _____

ALLERGIES: **(Please describe below what the participant is allergic to and the reaction seen)**

□ No known allergies □ Other: _____
□ Participant is allergic to: □ Food Medicine □ The environment (insect stings, hay fever, etc)

DIET, NUTRITION: □ Participant eats a regular diet □ Participant eats a regular vegetarian diet
□ Participant has special food needs **(please describe below).**

RESTRICTIONS: □ I have reviewed the program and activities and feel he/she can participate without restrictions
□ I have reviewed the program and activities and feel he/she can participate with the following restrictions or adaptations **(please describe below).**

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Immunization History: Provide the month and year for each immunization. Starred (★) immunizations must be current. Copies of immunization forms from health-care providers or state or local government are acceptable; please attach to this form.

Immunization	Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most Recent Dose Month/Year
Diptheria, tetanus, pertussis★ (DTaP) or (TdaP)						
Tetanus booster★ (dT) or (TdaP)						
Mumps, measles, rubella★ (MMR)						
Polio★ (IPV)						
Haemophilus influenzae type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox) ☐Had chicken pox Date:						
Meningococcal meningitis (MCV4)						

Tuberculosis (TB) test	Date:	☐ Negative	☐ Positive

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

Parent/Guardian Signature: _____ Date: _____

MEDICATIONS: The Cora Hartshorn Arboretum DOES NOT administer any medication. This information will only be utilized if there is a medical emergency.

Name of medication	Date started	Reason for taking it	When it is given	Amount or dose given	How it is given
			☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other time:_____		
			☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other time:_____		
			☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other time:_____		

Health-Care Providers:
Name of camper's primary doctor: _____ Phone: (_____)_____

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General Health History: ***Check "Yes" or "No" for each statement. Explain "Yes" answers below.***

1. Ever been hospitalized?	☐ Yes	☐ No	11. Had fainting or dizziness?	☐ Yes	☐ No
2. Ever had surgery?	☐ Yes	☐ No	12. Passed out/had chest pain during exercise?	☐ Yes	☐ No
3. Have recurrent/chronic illnesses?	☐ Yes	☐ No	13. Had mononucleosis ("mono") during the past 12 months?	☐ Yes	☐ No
4. Had a recent infectious disease?	☐ Yes	☐ No	14. If female, have problems with periods/menstruation?	☐ Yes	☐ No
5. Had a recent injury?	☐ Yes	☐ No	15. Have problems with falling asleep/sleepwalking?	☐ Yes	☐ No
6. Had asthma/wheezing/shortness of breath?	☐ Yes	☐ No	16. Ever had back/joint problems?	☐ Yes	☐ No
7. Have diabetes?	☐ Yes	☐ No	17. Have a history of bedwetting?	☐ Yes	☐ No
8. Had seizures?	☐ Yes	☐ No	18. Have problems with diarrhea/constipation?	☐ Yes	☐ No
9. Had headaches?	☐ Yes	☐ No	19. Have any skin problems?	☐ Yes	☐ No
10. Wear glasses, contacts, or protective eyewear?	☐ Yes	☐ No	20. Traveled outside the country in the past 9 months?	☐ Yes	☐ No

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

Mental, Emotional, and Social Health: ***Check "Yes" or "No" for each statement.***

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)?	☐ Yes	☐ No
2. Ever been treated for emotional or behavioral difficulties or an eating disorder?	☐ Yes	☐ No
3. During the past 12 months, seen a professional to address mental/emotional health concerns?	☐ Yes	☐ No
4. Had a significant life event that continues to affect the camper's life? (History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)	☐ Yes	☐ No

Please explain "Yes" answers in the space below, noting the number of the questions. The camp may contact you for additional information.

PARENT/GUARDIAN AUTHORIZATION:

This health history is correct and accurately reflects the health status of the participant to whom it pertains. The person described has permission to participate in all Cora Hartshorn Arboretum (CHA) activities expect as noted by me and/or an examining physician. I understand that this form will be shared on a "need to know" basis with CHA staff. In the event I cannot be reached, I authorize CHA staff to administer first aid or medical treatment when, in professional judgment of the physicians or medical personnel involved, such treatment is medically necessary. In authorizing emergency treatment, I agree to accept the determination of the treating physician, surgeon, or medical personnel that the treatment or examination rendered was medically necessary to protect the life, health, or mental well-being of my child.

I give CHA permission to use photographs taken of myself and/or my child while participating in programs at the CHA. No identifying information will be associated with the image. NOTE: To withhold photograph permission, please contact the CHA to complete the appropriate form.

I understand that there are some risks inherent in CHA programs, and I am willing to assume those risks on behalf of my child. I do hereby waive, release, and hold harmless the CHA, its officers, trustees, volunteers, and employees for any injury that may be suffered in the normal course of participation in activities.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Printed Name: _____