



324 Forest Drive South, Short Hills, NJ 07078  
P: 973.376.3587 F: 973.379.5059  
[www.hartshornarboretum.org](http://www.hartshornarboretum.org)

### HEALTH AND EMERGENCY FORM

Dates attending program: from \_\_\_\_\_ to \_\_\_\_\_  
(Month/Day/Year) (Month/Day/Year)

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
Diphtheria, 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)	<input type="checkbox"/> Had chicken pox Date: _____					
Meningococcal meningitis (MCV4)						

Tuberculosis (TB) test	Date: _____	<input type="checkbox"/> Negative	<input type="checkbox"/> Positive
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**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
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> 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? .....                         | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 11. Had fainting or dizziness? .....                         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Ever had surgery? .....                               | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 12. Passed out/had chest pain during exercise? .....         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Have recurrent/chronic illnesses? .....               | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 13. Had mononucleosis ("mono") during the past 12 months?... | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Had a recent infectious disease? .....                | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 14. If female, have problems with periods/menstruation?..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Had a recent injury? .....                            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 15. Have problems with falling asleep/sleepwalking? .....    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Had asthma/wheezing/shortness of breath?.....         | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 16. Ever had back/joint problems?.....                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. Have diabetes? .....                                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 17. Have a history of bedwetting?.....                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8. Had seizures? .....                                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 18. Have problems with diarrhea/constipation?.....           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 9. Had headaches? .....                                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 19. Have any skin problems?.....                             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 10. Wear glasses, contacts, or protective eyewear? ..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 20. Traveled outside the country in the past 9 months?.....  | <input type="checkbox"/> Yes | <input type="checkbox"/> 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)? .....   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Ever been treated for emotional or behavioral difficulties or an eating disorder?.....  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. During the past 12 months, seen a professional to address mental/emotional health concerns?.....  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Had a significant life event that continues to affect the camper's life?.....<br>(History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others) | <input type="checkbox"/> Yes | <input type="checkbox"/> 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: \_\_\_\_\_