THE CLIFFS
CLIMBING + FITNESS

Dates of Camp Attendance _____

Health History and Emergency Medical Authorization Form
Completion of this form is required by all participants.
A NYC school Health Examination Form is also required for The Cliffs Camp at LIC, Harlem, and Gowanus.

Camper's Name: Last_____ First_____ Middle_____ Birth Date: _____

Address: Street Address_____ City_____ State_____ Zip_____

Age at camp:_____ Gender: ☐ Female ☐ Male ☐ Other: _____ Pronouns: _____

PARENT/GUARDIAN INFORMATION

Child is in the custodial care of: ☐ Both Parents ☐ Mother Only ☐ Father Only ☐ Other: _____

Custodial Parent/Guardian:_____ Address (if different than child's): _____

Phone 1[Preferred]:_____ Phone 2:_____ E-mail: _____

Parent/Guardian 2:_____ Address (if different than child's): _____

Phone 1[Preferred]:_____ Phone 2:_____ E-mail: _____

EMERGENCY CONTACTS

Name:_____ Relationship:_____ Phone 1:_____ Phone 2:_____ Phone 3: _____

Name:_____ Relationship:_____ Phone 1:_____ Phone 2:_____ Phone 3: _____

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	☐	☐	

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

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: _____

Explain any dietary modifications: _____

Since your child's last health exam, has your child had:	Yes	No	Explain "yes" answers. Provide details and dates.
A serious injury requiring medical attention?	☐	☐	
An illness lasting longer than one week?	☐	☐	
An in-patient hospital or emergency room treatment?	☐	☐	
Restrictions from participating in any activities?	☐	☐	

Date of Last Health Exam: _____ Current Height: _____ Current Weight: _____

IMMUNIZATION HISTORY -- *[Please attach recent Health Assessment and Immunization Record]*

Are all immunizations current? ☐ Yes ☐ No If not, state reason(s): _____ DTP or DT (Tetanus) Date: _____

COVID-19 vaccination history: First dose: _____ Second dose: _____ Booster: _____

MEDICATION INFORMATION

The Cliffs does not have a licensed practitioner on site to administer medication. Participants requiring OTC or prescription medication must be capable of self-administrating independently or with supervision. Any medication must be delivered to camp by an adult in the original packaging, a provider order *and* a parent or guardian's written consent is required for both prescription and OTC medication.

Are any prescription medications being taken? ☐ Yes ☐ No Are any of the following used? ☐ Inhaler ☐ EpiPen
*If yes, please provide the provider order. The health director or camp director will follow-up with any additional information.

My child may apply their own sunscreen and direct a staff member to assist in applying:

*Participants must supply their own sunscreen. No staff member will assist in application unless specifically directed by the participant.

_____ Yes _____ No

MEDICAL CARE AND INSURANCE INFORMATION

Physician: _____ Phone: _____ Dentist/Orthodontist: _____ Phone: _____

Preferred Medical Facility: _____ Address: _____

Insurance Company: _____ Policy #: _____ Policy Holder: _____

Company Address: _____ City: _____ State: _____ Zip: _____

AUTHORIZATION FOR MEDICAL CARE

This health history is correct and complete as far as I know. The person herein described has permission to engage in all camp activities except as noted.
I hereby give permission to the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests.
I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child.
In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment,

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.