

# ROAD'S END FARM HORSEMANSHIP CAMP

TEL: 603/363-4900

FAX: 603/363-4949

P.O. Box 197 ♦ 149 Jackson Hill Road  
Chesterfield, New Hampshire 03443-0197

## HEALTH CERTIFICATE - Please Print or Type

Name of Camper \_\_\_\_\_ Birth Date \_\_\_\_\_  
First Middle Last

Name of Parent/Guardian \_\_\_\_\_ Relationship \_\_\_\_\_

Street Address \_\_\_\_\_ P. O. Box \_\_\_\_\_

City/Town \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Telephone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_

Office Telephone ( ) \_\_\_\_\_ Fax Number ( ) \_\_\_\_\_

If parent/guardian is unavailable in an emergency, please notify:

1. Name \_\_\_\_\_ Relationship \_\_\_\_\_  
 Home Telephone ( ) \_\_\_\_\_ Office Telephone ( ) \_\_\_\_\_

2. Name \_\_\_\_\_ Relationship \_\_\_\_\_  
 Home Telephone ( ) \_\_\_\_\_ Office Telephone ( ) \_\_\_\_\_

### MEDICAL HISTORY - To be completed by Parent/Guardian

<u>HEALTH HISTORY:</u>	Yes	No	<u>ILLNESSES:</u>	Yes	No	Date
Bed Wetting	_____	_____	Asthma*	_____	_____	_____
Behavior Problems	_____	_____	Chicken Pox	_____	_____	_____
Convulsions	_____	_____	Diabetes	_____	_____	_____
Ear Infections	_____	_____	Rheumatic Fever	_____	_____	_____
Heart Murmur	_____	_____	Other _____	_____	_____	_____
Operations _____						
Fractures _____			<u>ALLERGIES:</u>	Yes	No	Reaction
Sprains _____			Hay Fever	_____	_____	_____
Recurrent Pain _____			Insect Stings*	_____	_____	_____
Other _____			Medications	_____	_____	_____
			Latex	_____	_____	_____
			Food *	_____	_____	_____
			Daily Chores	_____	_____	_____
			Other _____	_____	_____	_____

Has your daughter menstruated? \_\_\_\_\_

If not, has she been told about it? \_\_\_\_\_

If so, is her menstrual history normal? \_\_\_\_\_

**\* If an Epi-Pen or an Inhaler will accompany your daughter to the Camp, please notify us at your earliest convenience to obtain the additional form that is required by the State of New Hampshire.**

**IMMUNIZATIONS:** As the State of New Hampshire mandates that a copy of each camper's formal immunization record accompany her health certificate, any child without such official documentation will not be admitted to the camp program at Road's End Farm.

HC	VA	DH	IC
Date: _____			

For nurse's use

**Please Complete Reverse Side, Sign, & Date**

Does this child have restrictions regarding

Diet? \_\_\_\_\_ Explain \_\_\_\_\_

Swimming/Diving? \_\_\_\_\_ Explain \_\_\_\_\_

Other \_\_\_\_\_ Explain \_\_\_\_\_

MEDICATIONS (Please be certain of name, strength, dose, and plan of administration.)

Medication	Dose	Used for

**All medications must be in original container with pharmacy labeling.**

SPECIAL INSTRUCTIONS OR COMMENTS

Has this child been treated for any medical condition in the last month? If so, please explain.

Does this child have any concerns that the nursing staff should be aware of? If so, please explain.

Do you have any particular instructions for the staff regarding the care of this child?

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PARENT'S/GUARDIAN'S AUTHORIZATION

This medical history is correct as far as I know and the child herein described has my permission to engage in any and all camp activities, except as noted by me above or by the examining physician below.

In the event that I cannot be contacted in an emergency, I hereby give permission to the physician selected by the camp's director to hospitalize, to secure proper treatment for, and to order injections, anesthesia, or surgery for the child named above. Furthermore, I give permission to members of the camp's staff to prudently provide and/or administer over-the-counter medications to her.

Signature \_\_\_\_\_ Relationship \_\_\_\_\_ Date \_\_\_\_\_

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PHYSICIAN'S STATEMENT - Please examine child within two years of her stay at camp.

\_\_\_\_\_ was examined and found to be in satisfactory health and apparently free from communicable diseases. Except as noted below, there are no apparent contra-indications to her participating in any or all camp activities including horsemanship and related farm chores. She has been properly immunized against tetanus for her upcoming experiences on a horse farm. **Her last tetanus booster was administered on \_\_\_\_\_.**  
Comments, special problems, allergies, etc.

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone (     ) \_\_\_\_\_

**This form, fully completed and signed, must accompany the camper to Road's End Farm.  
Do not send this health certificate to the camp.**