

# ROAD'S END FARM

HORSEMANSHIP CAMP ♦ RETREAT CENTER

(603)363-4900

(603)363-4600

P.O. Box 197 ♦ Jackson Hill Road  
Chesterfield, New Hampshire 03443-0197  
[www.roadsendfarm.com](http://www.roadsendfarm.com)

## HEALTH CERTIFICATE - Please print or type

### Camper Information

Name of Camper: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Preferred Name: \_\_\_\_\_ Pronouns: \_\_\_\_\_  
Street Address: \_\_\_\_\_ P.O. Box: \_\_\_\_\_  
City/Town: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
  
Primary Care Provider: \_\_\_\_\_ Primary Care Provider Phone: \_\_\_\_\_  
Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_  
Subscriber: \_\_\_\_\_ Insurance Phone Number: \_\_\_\_\_  
  
Camp Arrival Date: \_\_\_\_\_ Camp Departure Date: \_\_\_\_\_

### Parent Information - Please include the names of all legal parent(s)/guardian(s) below

Name of Parent/Guardian: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Street Address: \_\_\_\_\_ P.O. Box: \_\_\_\_\_  
City/Town: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Home Telephone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Work Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

Name of Parent/Guardian: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Street Address: \_\_\_\_\_ P.O. Box: \_\_\_\_\_  
City/Town: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Home Telephone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Work Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

### Emergency Contacts - If parent or guardian is unavailable in an emergency, please notify

1. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Home Telephone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Work Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

2. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Home Telephone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Work Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

Camper Last Name \_\_\_\_\_

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## Medical History - To be completed by parent or guardian

Camper Height: \_\_\_\_\_ Camper Weight: \_\_\_\_\_

## **General Health History** - Indicate yes or no for each statement

Has/does the camper:

Ever been hospitalized \_\_\_\_\_ Have asthma\* \_\_\_\_\_

Ever had surgery \_\_\_\_\_ Have a heart murmur \_\_\_\_\_

Have recurrent/chronic illnesses \_\_\_\_\_ Have diabetes \_\_\_\_\_

Had an illness/injury in the last year \_\_\_\_\_ Have a history of bedwetting \_\_\_\_\_

Have seizures \_\_\_\_\_ Have problems with diarrhea/constipation \_\_\_\_\_

Have headaches \_\_\_\_\_ Have any skin problems \_\_\_\_\_

Have fainting or dizziness \_\_\_\_\_ Have joint or back pain \_\_\_\_\_

Have vision or hearing problems \_\_\_\_\_ Have other medical problems \_\_\_\_\_

*Please explain any yes answers in the space below*

## **Allergies** - Indicate yes or no for each allergy

Pollen/Hay Fever \_\_\_\_\_ Medication \_\_\_\_\_

Animals \_\_\_\_\_ Latex \_\_\_\_\_

Bee/Insect \_\_\_\_\_ Food \_\_\_\_\_

Daily Chores \_\_\_\_\_ Other \_\_\_\_\_

*Please explain the reaction and treatment for any yes answers in the space below*

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## Mental, Emotional and Social Health - Indicate yes or no for each statement

Has/does the camper:

Ever been treated for ADD/ADHD \_\_\_\_\_ Attend regular therapy\* \_\_\_\_\_

Have a history of an eating disorder \_\_\_\_\_ Have a history of self-harm \_\_\_\_\_

Have a history of depression \_\_\_\_\_ Have a history of anxiety \_\_\_\_\_

Have a history of psychiatric illness \_\_\_\_\_ Receive accommodations at school \_\_\_\_\_

Have a history of residential treatment \_\_\_\_\_ Had a challenging life event \_\_\_\_\_

*\*If your camper needs to attend therapy appointments while at camp, please contact Sarah to coordinate*

*Please explain any yes answers in the space below*

Has your camper ever menstruated: \_\_\_\_\_

If yes, do they have regular menstrual cycles? \_\_\_\_\_

If no, have they been educated about menstruation? \_\_\_\_\_

## Medications

Please include any medications, vitamins or supplements your camper takes on a daily basis\*\*

Name of Medication	Date Started	Reason for Taking	Amount or Dose	How it is given	When it is given

This camper will not take any daily medications while at camp

*\*\*All Medications must be in their original container with pharmacy labeling. No loose pills, medication planners or non-pharmacy labeled containers will be permitted at camp. Melatonin, supplements, vitamins, herbs, natural remedies, OTC pain medication, etc., must be left with the camp nurse. Self-administration of medications, vitamins or supplements by campers is not permitted.*

Camper Last Name \_\_\_\_\_

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The following non-prescription medications may be stocked with the Camp Nurse and are used on an as needed basis to manage illness and injury. *Please cross out the medications your camper should not be given.*

Antibiotic Ointment	Acetaminophen (Tylenol)
Calamine Lotion	Ibuprofen (Advil/Motrin)
Hydrocortisone Cream	Phenylephrine (Decongestant)
Tinactin (Athlete's Foot Cream)	Pseudoephedrine (Decongestant)
Swimmers Ear Drops	Cough Drops
Aloe Vera Gel	Oral Lidocaine Spray (Sore Throat)
Epsom Salt Soaks	Guaifenesin Syrup (Expectorant)
Calcium Carbonate (Tums)	Loratadine (Claritin)
Bismuth Subsalicylate (Pepto Bismol)	Diphenhydramine (Benadryl)
Polyethylene Glycol Powder (MiraLAX)	Cetirizine (Zyrtec)
Aluminum hydroxide/magnesium hydroxide/simethicone (Mylanta)	Oral Rehydration (Pedialyte)

## Additional Information

Does your camper have any concerns that the Road's End Farm staff should be aware of? Do you have any particular instructions for the staff regarding the care of your camper? If so, please explain.

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## Required Documentation

Please remit the following documentation by mail or email a minimum of 30 days before your camper's session.

1. A signed "Fit for School/ Camp" form your camper's primary care provider or a signed summary from a wellness visit or physical from the last two calendar years.
2. A copy of the front and back of the camper's health insurance card.
3. An Immunization Record. The State of New Hampshire mandates that a copy of each camper's formal immunization record accompany their Health Certificate. If the camper is vaccinated against COVID-19, please submit documentation as part of the immunization record. Any camper without such official documentation will not be admitted to the camp program at Road's End Farm.
4. If an Epi-Pen or an Inhaler will accompany your camper to the Camp, please notify us at your earliest convenience to obtain the additional form that is required by the State of New Hampshire. Please note that the Epi-Pen and/or Inhaler must be accompanied by a prescription for the device.
5. (Optional) Any additional documentation that would be helpful for us to have on file regarding your camper's health.

## Disclosure

I will remit this health form within 30 days of receiving my session confirmation, or I will forfeit my camper's space in the session. I will return all required documentation a minimum of 30 days of my camper's session. This medical history is correct as far as I know it and the child herein described has my permission to engage in any and all camp activities, except as noted by me above. Should my camper have any health or medication changes prior to camp, I will provide a written update. If my camper is found to have any previously known health issues that are not disclosed on this form, I will be required to pick up my camper immediately and forfeit the rest of my camp fee. 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 medications, 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 them.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Camper Last Name \_\_\_\_\_