Springfield College Camp Massasoit/East Campus
263 Alden Street
Springfield, MA 01109-3797

2026 Emergency Contact and Health Record

Child's Name (First & Last):_____ DOB:_____/_____/_____

Parents/Guardian:

Name:_____ Relation to Child:_____

Last First

Address:_____

Street Town/City State Zip Code

Phone (Home): (_____) _____-_____ Phone (Work): (_____) _____-_____Phone (Cell): (_____) _____-_____

Name:_____ Relation to Child:_____

Last First

Address (if different from above):_____

Street Town/City State Zip Code

Phone (Home): (_____) _____-_____Phone (Work): (_____) _____-_____Phone (Cell): (_____) _____-_____

<u>One Additional Emergency Contact</u>:

Name:_____ Relation to Child:_____

Last First

Address:_____

Street Town/City State Zip Code

Phone (Home): (_____) _____-_____Phone (Work): (_____) _____-_____Phone (Cell): (_____) _____-_____

<u>PLEASE COMPLETE- REQUIRED</u>

I, _____ give permission for my child to use hand sanitizer, that has at least 60% alcohol, provided by East Campus/Camp Massasoit in the event my child isn't near an adequate handwashing facility.

Please Circle YES NO

<u>Health History</u>: Provide dates and other information requested or indicate N/A (not applicable) if appropriate.

Ear Infections	_____	Chicken Pox	_____	Measles	_____
Convulsions	_____	German measles	_____	Diabetes	_____
Mumps	_____	Bleeding disorder	_____	Tuberculosis	_____

Allergies:_____

Operations/Serious Injuries:_____

Disability or chronic or recurring illness:_____

Any current mental, emotional, social health, developmental, or psychological conditions requiring medication, treatment or special considerations while at camp:_____

_____

Current medications:_____

Family Medical Insurance Carrier:_____ Policy # _____

Name of Family Physician: _____ Phone #_____

Signature of Parent/Guardian: _____ Date: _____

IMPORTANT: East Campus/Camp Massasoit must be notified immediately if a camper has been exposed to a communicable disease during or within three weeks prior to attendance.

Immunizations: This section must be completed by a licensed health care provider or attach a copy of immunization documentation or alternative proof of immunity.

REQUIRED IMMUNIZATIONS (Campers under 18 years of age)	**DATE (Month/Day/Year)**
MMR (1st dose age 12 months or older)	
Measles #2 or MMR #2 (Given at age 4 – 6 years and at least 1 month after 1st dose)	
Polio (3 doses of OPV or IPV or 4 doses of mix IPV and OPV)	**#1** **#2** **#3** **#4**
Diptheria and Tetanus Toxoids and Pertussis (4 doses of DTaP/DTP/DT/Td. Booster dose of Td required if more than 10 years since last dose)	**#1** **#2** **#3** **#4** **Booster** (if applicable)
Hepatitis B (3 doses if born on or after January 1, 1992)	**#1** **#2** **#3**
OPTIONAL IMMUNIZATIONS (Campers under 18 years of age)	**DATE (Month/Day/Year)**
COVID- 19	**#1** **#2** **Booster** (if applicable)

LEAD SCREENING: _____

Effective 3/01/90 Massachusetts State Law requires all children, regardless of risk, shall be screened at least once between the ages of 9-12 months and annually until the age of 48 months. Children who are determined to be at high risk for lead exposure must be screened every 6 months and 3 years and yearly from 3 years to 6 years. Children must present evidence of having been previously screened as a condition for entry to kindergarten.

Physical Examination By a Physician: This section must be completed by a physician or attach a copy of a physical examination conducted by a physician during the preceding 24 months.

DATE OF MOST RECENT PHYSICAL EXAM: _____

Height:	Eyes:	Abdomen:
Weight:	Vision:	Genitalia, Hernia:
BP:	Ears, Nose, Throat:	Musculoskeletal:
HCT or Hgb:	Heart:	Neurological Exam:
Urinalysis:	Lungs:	Skin:

Recommendation for Camp Participation:

- Is person capable of participating in active camp program(s)? ◯ Yes ◯ No
- Please explain any restriction(s) _____
- Is person currently taking medication(s)? _____
- List any medications to be administered by Camp Health Supervisor _____

_____

_____

Signature of Health Care Provider: _____ Date: _____

Printed Name of Health Care Provider: _____ Phone: _____

Office Address: _____