COUNTY OF BERGEN
DEPARTMENT OF HEALTH SERVICES
Division of Public Health
Office of Public Health Nursing
1 Bergen County Plaza • Fourth Floor • Hackensack, New Jersey 07601-7076
(201) 634-2600 • FAX (201) 336-6086
www.bergencountynj.gov

BERGEN COUNTY ZOO CAMP
ENROLLMENT HEALTH ASSESSMENT FORM

PURPOSE: Information provided is used by the Bergen County Department of Health Services to (1) Verify child health and immunization status (2) Assess special child program considerations and/or restrictions to participate (3) Plan for the delivery of program participation and any emergency medical procedures.

USES: All provided information is confidential and shared with other staff as needed to protect the child's safety and comfort during program hours. **DISCLOSURE**: Information is voluntary; however, if information is not provided, individuals may not be able to participate in zoo activities.

SECTION I. TO BE COMPLETED BY PARENT OR LEGAL GUARDIAN:

Name of Child: ______________________________ Date of Birth: _/______/______

Age: __________ Male or Female: ______________ Grade in School/Last Grade Completed: ______________________

Name of Parent or Legal Guardian: ____

Home Address: ____

Cell Phone #1: ____________________ Name: ____________________ Relationship: ______________

Cell Phone #2: ____________________Name: ____________________ Relationship: ______________

Additional Name & Contact Number: ____

Family Email Address: ____

Emergency Contact Information:

Name of contact: ______________________________

Relationship To Child: ___________________________

Phone #: ____________________________________

CHILD'S NAME: ____ CHILD'S DATE OF BIRTH: ______________________________

Does the above-named child currently have or been treated for any of the following?

YES	NO	CONDITION	EXPLAIN
		Abdominal/Digestive Problems	
		ADD/ADHD	
		Asthma **Last Hospital Visit** (MM/YY) ______/______	**Please complete and return attached Asthma Action Plan**
		Autism Spectrum Disorder	
		Behavioral/Conduct Concerns (anxiety, school phobia)	
		Bleeding disorders	
		Chest Pain with Exercise	
		Current Cancer Treatment	
		Diabetes (**If yes, sugar is checked ___x/day**)	
		Difficulty with social interactions	
		Excessive Fatigue or shortness of breath with exercise	
		Excessive shyness	
		Fainting Spells	
		Heart Disease (Any Physical limitations?)	
		High Blood Pressure/Hypertension	
		Kidney Dialysis (**Dialysis Days**: **Mon Tue Wed Thru Fri**)	
		Learning Difficulties	
		Lung/Respiratory Disease	
		Psychiatric/psychological/emotional difficulties	
		Recent bone injury (MM/YY) ______/_______	
		Recent head injury/loss of consciousness	**(MM/YY ______/________)**
		Required restricted physical activity	
		Seizures (**last seizure activity** MM/YY ______/_____)	**Type**:
		Psychiatric/psychological/emotional difficulties	
		CONTINUED ON OTHER SIDE	
YES	**NO**	**CONDITION**	**EXPLAIN**
		Sickle Cell Disease	
		Speech/Language Delays	
		Other:	

ALLERGIES/ ASTHMA/SENSITIVITIES:

Are the above-named child allergic to or have any adverse reaction to any of the following:

YES	NO	ALLERGY OR REACTION TO:	EXPLAIN:
		Medication	
		Food – Allergy (FARE Form and medication required)	
		Food – Sensitivity (Preferred that child is kept away from this but medication not required)	
		Plants/Trees	
		Bees/Insect bites	
		Other	

IF YOUR CHILD HAS A HISTORY OF ALLERGIC REACTION TO ANY OF THE ABOVE, PLEASE BE SURE TO COMPLETE AND RETURN THE FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN. YOUR CHILD'S NON-EXPIRED ALLERGY MEDICATIONS MUST ACCOMPANY YOUR CHILD TO ZOO CAMP.

CHILD'S NAME: _______________________________________ **CHILD'S DATE OF BIRTH:** ______________________________

HEALTH NEEDS:

Please indicate if the above-named child uses any of the following:

	Wears contact lenses/corrective glasses
	Wears orthodontic appliance and/or braces
	Wears hearing aid(s)
	Wears an insulin pump
	Wears medical ID for ____
	Wears orthopedic device
	Other:

IMMUNIZATIONS: All campers shall be immunized with the vaccinations required for school attendance, as appropriate for the camper's age, according to the immunization schedule set forth at Immunization of Pupils in School, N.J.A.C. 8:57-4.1.

**************IMMUNIZATION DATES ARE REQUIRED (MM/DD/YYYY). "Up to date" is NOT ACCEPTABLE! **********************

Please attach up to date copy of immunizations from school or doctor's office.

PARTICIPATION RECOMMENDATIONS:

Please indicate the above-named child's physical activity abilities:

	Normal physical Activity
	Restrictions (please explain)
	Additional comments:

SPECIAL MEDICAL CONSIDERATIONS:

Please describe any special program needs, considerations or restrictions which the above-named child requires to participate in the Bergen County Zoo Camp:

____

____

Is above named child able to fully participate? Yes ______ No________ Date________________________________

Print Parent/Guardian Name____

Signature of Parent/Guardian____

Please feel free to attach additional significant information that will assist us in providing an enriching camp experience for your camper.

Thank you!