

**PLEASE NOTE:**  
**This sheet MUST be filled out and signed below.**

**SUMMER CAMPS**  
**DEXTER SCHOOL – SOUTHFIELD SCHOOL**  
**20 Newton Street**  
**Brookline, Massachusetts 02445-7498**  
**Telephone: 617/522-5544 Fax: 617/454-2734**

This side to be filled out by parent/guardian of minor -- PLEASE PRINT

Camper/Counselor Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_  
Last First Middle Initial

Parent/Guardian Name \_\_\_\_\_ Phone \_\_\_\_\_  
 Home Address \_\_\_\_\_ Work/Cell Phone \_\_\_\_\_  
Street and Number City State Zip Code

Second Parent/Guardian/Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_  
 Home Address \_\_\_\_\_ Work/Cell Phone \_\_\_\_\_  
Street and Number City State Zip Code

If not available in an emergency, contact: Name \_\_\_\_\_ Phone \_\_\_\_\_

**Health History (please check and give approximate dates if possible)**

Asthma _____	Convulsions/Seizures _____	Drug Allergy _____
Frequent Ear Infections _____	Concussion _____	Food Allergy _____
Diabetes _____	Psychiatric Treatment _____	Insect Sting Allergy _____
Heart Defect/Disease _____	Hypertension _____	Poison Ivy, Oak, Sumac _____
Mononucleosis _____	Other _____	Hay Fever _____

If "yes" to any of the above, please explain \_\_\_\_\_

Has this child ever required psychiatric counseling or hospitalization \_\_\_\_\_  
 Operations or serious injuries (please include dates) \_\_\_\_\_

Disabilities or chronic/recurring illnesses \_\_\_\_\_

Any specific activities to be encouraged or limited by a physician's advice \_\_\_\_\_

Dietary Modifications \_\_\_\_\_

Medication(s) to be administered at camp (send with instructions): \_\_\_\_\_

Suggestions or health related information for summer personnel: \_\_\_\_\_

**For Female:** Has this person menstruated? \_\_\_\_\_ If not, has she been told about it? \_\_\_\_\_  
 If yes, is her menstrual history normal? \_\_\_\_\_ Any special considerations? \_\_\_\_\_

Name of dentist/orthodontist \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Name of family physician \_\_\_\_\_ Phone ( ) \_\_\_\_\_

**IMPORTANT – THIS FORM MUST BE COMPLETED FOR ATTENDANCE**

This history is correct as far as I know, and the person herein described has permission to engage in all prescribed summer camp activities except as noted. Emergency Authorization: I hereby give permission to the medical personnel selected by the program director to order x-rays, routine tests and treatment for me/or my child, and in the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the program director to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for me/or my child as named above. This form may be photocopied. I also give permission for routine medical care for my child by Dexter School Summer Camps.

Signature of parent/guardian or adult staff member \_\_\_\_\_  
 Print Name \_\_\_\_\_ Date \_\_\_\_\_

If for religious reasons you cannot sign this form, then Dexter School Summer Programs should be contacted for a legal waiver, which must be signed for attendance.

Information Below is for Office Use Only

Day Camp 1 2 3 4 5 6 7 8	Boys Hockey Camp 1 2 3 4	Sailing 1 2 3 4 5 6 7 8	Academic Enrichment 1 2 3 4 5 6 7
DM DT DJ D1 D2 D3 D4	Girls Hockey Camp 1	Marine Science 1 2 3 4 5 6 7 8	Science & Technology 1 2 3 4 5 6 7 8

