Child's Name: ____________________

Form Completed by: ____________________
Relationship to Child: ____________________

Date: ____________________

FAMILY AND HOME LIFE

1) Siblings:
   a) Name: ____________________ Age: ______
      Relationship? ____________________ Resides in same home? Yes ☐ No ☐
   b) Name: ____________________ Age: ______
      Relationship? ____________________ Resides in same home? Yes ☐ No ☐
   c) Name: ____________________ Age: ______
      Relationship? ____________________ Resides in same home? Yes ☐ No ☐

2) Does your child get along with his/her: Parents? Yes ☐ No ☐ Siblings? Yes ☐ No ☐

3) Are there additional family members (i.e. – stepsiblings, step-parents, grandparents) of whom we should be aware? Please identify name and relation: ____________________

____________________ ____________________

PHYSICAL – PSYCHOLOGICAL

1) How does your child feel about attending camp? ____________________

2) Has your child been told about the educational and religious activities and expectations of Camp?
   Yes ☐ No ☐

3) List the activities in which your child excels: ____________________

4) List the activities, habits or skills in which you would like your child to improve: ____________________

____

5) Does your child have problems with:
   Tantrums ☐ Weeping spells ☐ Nightmares ☐ Personal hygiene ☐

6) Is your child afraid of:

Darkness	☐	Mice	☐
People	☐	Animals	☐
Dogs	☐	Water	☐
Cats	☐	Lightning/Thunder	☐

7) Has your child been under any educational or psychological guidance in the past two years? Yes ☐ No ☐
   Please describe: ____________________

____

8) Are there any past illnesses of which we should be aware? Yes ☐ No ☐
   If yes, please explain: ____________________

____

9) Does your child take any daily medication? Yes ☐ No ☐
If yes, please specify what medications and dosages are taken during the school year: ________
____
____

10) Will your child be on daily medication this summer? Yes ☐ No ☐
If yes, please specify what medications and dosages: ________
____
____

11) Was your child hospitalized during the past year? Yes ☐ No ☐
If yes, please specify dates and reasons: ________
____
____

12) Please indicate which of the following applies to your child:
☐ Tendency to colds ☐ Fainting spells ☐ Constipated frequently ☐ Tendency to gain/lose weight

13) Is your child unable to participate in some activities? Yes ☐ No ☐
If yes, please specify: ________
____

14) During the night, does your child:
☐ Have trouble falling asleep ☐ Wet the bed ☐ Walk in his/her sleep
☐ Wake up or call out in sleep ☐ Talk in sleep

15) How does your child resolve his/her sleep issues? Please explain: ________
____
____

16) What time does your child normally go to sleep at home? ________

17) Does your child have any food allergies? Yes ☐ No ☐
If yes, please describe: ________
____

18) Are certain foods not allowed for medical reasons? Yes ☐ No ☐
If yes, please describe: ________
____

19) Is your child fussy about foods? Yes ☐ No ☐

20) I would like my child on the vegetarian plan: Yes ☐ No ☐

21) Please add any information you feel may help us in making your child's summer more pleasant:
____
____
____
____