Camper: _____ **Address:** _____ **DOB**_____
Last Name **First**

CAMPER MEDICAL FORM 2017

Parent or guardian please print or type all information clearly. Please fill out **both sides** of form. This information is important in the event of an accident at camp. Your child may not receive necessary and timely treatment without it.

Permission to Provide Necessary Treatment or Emergency Care (Please Read Carefully):

Parent/Guardian Authorizations: This health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted. I hereby give permission to the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization for the person named above. This completed form may be photocopied for trips out of camp. **Note: Camp Health Insurance provides secondary coverage only. The parent's insurance carrier will be billed first for all accidents and illnesses at camp.

Parent/Guardian Signature: (Your child will *not* be admitted to camp without this signature).

_____
Signature Printed **Witness**

Emergency Contact (If parents CANNOT be reached) _____

Restrictions at camp (please list): _____

Insurance Information

(Your child will *not* be admitted to camp without this information.)
Is the camper covered by family medical/hospital insurance? ☐ Yes ☐ No
If so, indicate carrier or plan name._____ Group No. _____
Name of insured _____ Relationship to camper_____
Policy holder insurance ID No. _____ Medicaid Number_____

Immunizations

You must supply all immunization information, including dates, for camper to be admitted to camp.

Vaccine For:	Mo./Yr.	Mo./Yr.	Mo./Yr.	Mo./Yr
DTP (tetanus/dihtheria)				
Tetanus				
Polio				
MMR				
Or Measles				
Or Mumps				
Or Rubella				
Haemophilus Influenza B				
Hepatitus B				
Varicella (Chicken Pox)				
BCG				

Date of camper's last physical exam:_____

The camper must have had a physical exam no more than 2 years before the camp session for which they are registering

Medical Care Providers:

Name of family physician:
_____
Phone_____
Address_____

Name of family dentist/orthodontist:
_____
Phone_____
Address_____

Check which of the following diseases the camper has already had:

- ☐ Measles
- ☐ Chicken Pox
- ☐ German Measles
- ☐ Mumps
- ☐ Hepatitis
- ☐ Small Pox

Does the camper have or has had in the past, any of the following:

	past	present
Tuberculosis	☐	☐
Hepatitis B	☐	☐
Hepatitis C	☐	☐
Bleeding Disorders	☐	☐
Rheumatic Fever	☐	☐
HIV Positive	☐	☐
Heart Disease	☐	☐
Other	☐	☐

over

Camper: _____ Address:_____ DOB _____
Last Name First

Health History 2017

The following information must be filled out by the parent/guardian (when the camper is a minor), or adult camper or staff member. The intent is to provide camp health care personnel the background to provide appropriate care. Keep a copy of the completed form for your records. Any change to this form should be provided to camp health personnel upon camper's arrival in camp. Provide complete information so that the camp can be aware of your needs. This form is confidential, observed only by camp health staff, medication staff and NYS Department of Health

General Questions: Explain "yes "answers below or on a separate piece of paper attached to this form.

***The participant has/has had**:*

Y	N		Y	N		Y	N	
□	□	a recent injury, illness or infectious disease	□	□	back problems	□	□	problems with joints (e.g. knees, ankles)
□	□	a chronic or recurring illness/condition	□	□	been hospitalized	□	□	any skin problems (e.g. itching, rash, acne)
□	□	an orthodontic appliance	□	□	surgery	□	□	frequent headaches
□	□	glasses, contacts, or protective eyewear	□	□	diabetes	□	□	a head injury
□	□	problems with diarrhea/constipation	□	□	asthma	□	□	frequent ear infections
□	□	problems with sleepwalking	□	□	seizures	□	□	a history of bedwetting
□	□	dizziness or fainting during or after exercise	□	□	eating disorder	□	□	chest pain during or after exercise
□	□	If female: abnormal menstrual cycle	□	□	a diagnosed heart murmur	□	□	high blood pressure
□	□	emotional difficulties for which professional help was sought						

Use this space to provide any additional information about the camper's behavior and physical, emotional or mental health about which the camp should be aware. _____

Allergies (list all known) Describe reaction and management of the reaction:

Medication allergies (list all) _____

Food Allergies (list all) _____

Other allergies (list all) _____

Medications to be taken at camp

Please list all medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage and the frequency of administration.

☐ **This person takes no medication on a routine basis.**

☐ **This person takes medication as follows: (attach additional pages for more medications)**

PHYSICIAN'S STANDING ORDERS FOR THIS CAMPER

Health Care Provider MUST Fill Out and Sign

DATE _____

PATIENT/CAMPER: _____

DIAGNOSIS: _____

Drug	Acetaminophen	Ibuprofen	Pepto-Bismol	Benadryl	Maalox	Imodium	Cough Medicine
Permisssion to Administer							
Dosage							

OTHER: _____

PRESCRIPTION MEDICATION: (please list)_____

_____ _____
Health Care Provider Signature & Date **Parent/Guardian Signature & Date**

OMISSION OF SIGNATURES MAY DELAY NECESSARY MEDICAL ATTENTION

Identify any medications the camper takes during the school year that the camper does not/may not take during the summer:

_____