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

**Page 1 to be completed by Health Care Provider**

# CAMPER MEDICAL FORM (Physician)

No Line should be left blank- write NONE or N/A

## IMMUNIZATION & HEALTH HISTORY

*All immunization information, including dates, for the camper must be submitted in order for camper to be admitted to camp. Campers must have current immunizations or proof of a MEDICAL exemption in order to attend camp.*

| VACCINE | Mo./Yr. | Mo./Yr. | Mo./Yr. | Mo./Yr. |
|---|---|---|---|---|
| DTP (tetanus/diphtheria) | | | | |
| Tetanus | | | | |
| Polio | | | | |
| MMR | | | | |
| Or Measles | | | | |
| Or Mumps | | | | |
| Or Rubella | | | | |
| Haemophilus Influenza B | | | | |
| Hepatitis B | | | | |
| Varicella (Chicken Pox) | | | | |
| Meningococcal conjugate vaccine (MenACWY) 7-12 grades only | | | | |

**Check the following disease camper had:**

□ Measles □ Mumps □ Heart Disease □ Small Pox
□ Chicken Pox □ West Nile Virus □ Tuberculosis □ Meningitis
□ German Measles □ Hepatitis C □ Hepatitis A □ Hepatitis B
□ Lyme Disease

### Health History

1. Last physical exam date: _____
(*The camper must have a completed physical exam no more than 2 years before the camp session for which they are attending.*) NOTE: a COPY of the physical must be included.

2. Are there any restrictions for this camper while attending camp?
_____

3. Additional health information or special instructions for this camper?
_____

4. **MEDICAL CONCERNS/DIAGNOSIS:** _____

5. **ALLERGIES:** _____

## MEDICATIONS TO BE TAKEN AT CAMP (to be completed by physician)

*Please list all medications (including over-the-counter or nonprescription drugs) taken routinely by camper.*

□ This camper takes no medication on a routine basis.

□ This camper takes medication as follows:

| MEDICATION* | REASON FOR TAKING | DOSAGE | SCHEDULE TIME |
|---|---|---|---|
| | | | □ Breakfast □ Lunch □ Dinner □ Bedtime |
| | | | □ Breakfast □ Lunch □ Dinner □ Bedtime |
| | | | □ Breakfast □ Lunch □ Dinner □ Bedtime |
| | | | □ Breakfast □ Lunch □ Dinner □ Bedtime |
| | | | □ Breakfast □ Lunch □ Dinner □ Bedtime |

***Attach additional pages for more medication requirements***

## NON-PRESCRIPTION MEDICATION STANDING ORDERS (to be completed by physician)

*Upon documented approval by camper's physician, the following non-prescription medications are available in the camp's infirmary and will be administered at the discretion of the Camp Health Director.*

| Non-Prescription Medication | Tylenol or generic | Advil or generic | Neosporin or generic | Benadryl or generic | Calamine lotion or generic | Tums or generic | Imodium or generic | Robitussin or generic |
|---|---|---|---|---|---|---|---|---|
| **Permission to Administer** | □ Yes □ No | □ Yes □ No | □ Yes □ No | □ Yes □ No | □ Yes □ No | □ Yes □ No | □ Yes □ No | □ Yes □ No |
| **Dosage and Schedule** | Per label instructions for weight/age | Per label instructions for weight/age | Per label instructions for weight/age | Per label instructions for weight/age | Per label instructions for weight/age | Per label instructions for weight/age | Per label instructions for weight/age | Per label instructions for weight/age |

**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.**

**Physician's Signature: _____ Date: _____**

**Physician's Address and Phone Number: _____**

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

# CAMPER MEDICAL FORM (Parent/Guardian)

No Line should be left blank- write NONE or N/A

**Page 2 to be completed by Parent/Guardian**

Please complete all information clearly. This information is important in the event of an accident at camp. Your child may not receive necessary and timely treatment without it. **NOTE:** Bring sufficient supply of medication to last the entire time at camp. Keep the medication in the original packaging/bottle which identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

## Contact Information:

**Parent/Guardian Name:** _____
Primary Phone #: _____
Secondary Phone #: _____

**Emergency Contact Name:** _____
Primary Phone #: _____
Secondary Phone #: _____

## Medical Care Providers:

**Physician Name:** _____
Phone #: _____
Address: _____

**Dentist/Orthodontist:** _____
Phone #: _____
Address: _____

**Allergies:** Please describe reaction and management of all known allergies:

| Medication Allergies | Food Allergies | Other Allergies |
|---|---|---|
| | | |

## Health History

The following information must be filled out by the parent/guardian (when the camper is a minor) or adult camper. 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, medical 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 | □ | □ | seizures | □ | □ | frequent ear infections |
| □ | □ | problems with sleepwalking | □ | □ | eating disorder | □ | □ | a history of bedwetting |
| □ | □ | dizziness or fainting during or after exercise | □ | □ | a diagnosed heart murmur | □ | □ | chest pain during or after exercise |
| □ | □ | if female: abnormal menstrual cycle | □ | □ | high blood pressure | □ | □ | emotional difficulties for which professional help was sought |

Please provide additional information about the camper's behavioral, physical, emotional or mental health about which the camp should be aware.

_____

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

## 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 _____

## Permission to Provide Necessary Treatment of 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 insurance provides secondary coverage only. The parent's insurance carrier will be billed first for all accidents and illnesses at camp.

**I understand that I am required to submit this CAMPER MEDICAL FORM along with camper's IMMUNIZATION RECORDS in order for admittance to camp.**

## Parent/Guardian Signature & Date: _____

**(Your child will *not* be admitted to camp without this signature)** **Name Printed** **Signature** **Date**