Dates will attend camp: from _____ to _____

Camper Name _____ LAST _____ FIRST _____ MIDDLE _____ (For Camp Use) Cabin or Group _____

Medical
History for Campers, Volunteers & Staff

1. Campers must bring this completed form, **Signed by the parent and physician,** to camp. Campers without a completed form will not be permitted to attend camp.
2. Please complete this form accurately and carefully. In the event of an emergency, the information on this form is crucial.
3. Pages 1 and 2 are to be completed by the parent/ guardian.
4. Pages 3 and 4 must be completed by a health care provider.
5. Parent/guardian must sign and date the Authorization for Health Care section at bottom of page 4.

Privacy Notification

Because this form asks for personal information, the Personal Privacy Protection Law requires that you be given this notice. Information requested on this form is pursuant of Public Health Law 225, §7-28. Information is needed to alert camp administration to special medical needs of the camp population. It will be treated as confidential medical information and will be given to appropriate medical service providers in case of an emergency. This form will be filed under the Environmental Education Camp Record File maintained by the Camp Director of the appropriate camp.
FAILURE TO PROVIDE THIS INFORMATION WILL RESULT IN THE CAMPER NOT BEING ALLOWED TO ATTEND CAMP.

Camper Information

Camper Name: _____
First Middle Last

Gender: □ Male □ Female Birth Date _____ Age on arrival at camp: _____

Home Address: _____
Street Address City State Zip Code

County Residence _____

Emergency Information
Parent/guardian with legal custody to be contacted in case of illness or injury:

Name: _____ Relationship to Camper: _____

Home Phone (___) _____ Cell (___)_____ Work (___)_____

Home Address: _____
(If different from above) Street Address City State Zip Code

Second parent/guardian or other emergency contact:

Name: _____ Relationship to Camper: _____

Home Phone: (___) _____ Cell (___)_____ Work (___)_____

Additional contact in event parent(s)/guardian(s) can not be reached:

Name(s): _____ Relationship to Camper: _____

Home Phone: (___) _____ Cell (___)_____ Work (___)_____

Medical Insurance Information:

This camper is covered by family medical/hospital insurance □ Yes □ No

Insurance Company _____ Policy Number _____

Subscriber _____ Insurance Company Phone Number (___)_____

Medical History
Campers personal medical history and information must be filled out by the parent/guardian. For questions answered "yes" explain in the area below the question. If there is not enough room, attached another piece of paper.

Allergies: ☐ No known allergies
☐This camper is allergic to: ☐ Food ☐Medicine ☐ The environment (insect stings, hay fever, etc.) ☐Other
(Please describe below what the camper is allergic to and the reaction seen.)

Diet, Nutrition: ☐ This camper eats a regular diet. ☐ This camper eats a regular vegetarian diet.
☐ This camp eats a vegan diet. ☐ This camper has special food needs. ***(Please describe below.)***

Restrictions: ☐ have reviewed the program and activities of the camp and feel the camper can participate without restrictions.
☐ have reviewed the program and activities of the camp and feel the camper can participate with the following restrictions or adaptations. ***(Please describe below.)***

General Questions (Explain "yes" answers below)
Has/does camper:

1. Had any recent injury, illness or infectious disease?	yes / no	16. Ever had a problems with joints?	yes / no
2. Had a chronic or recurring illness/condition?	yes / no	17. Orthodontic, appliance being brought to camp?	yes / no
3. Ever been hospitalized?	yes / no	18. Have any skin problems?	yes / no
4. Ever had surgery?	Yes / no	19. Have diabetes?	yes / no
5. Have frequent headaches?	yes / no	20. Have asthma?	yes / no
6. Ever had a head injury?	yes / no	21. Had mononucleosis in past 12 months?	yes / no
7. Ever been knocked unconscious?	yes / no	22. Have problems with diarrhea/constipation?	yes / no
8. Wear glasses, contacts or protective eye wear?	yes / no	23. For females: this camper knows about menstruation and/or has a normal menstrual history.	yes / no
9. Ever had frequent ear infections?	yes / no	24. If female, have an abnormal menstrual history?	yes / no
10. Ever passed out during exercise?	yes / no	25. Have history of bed-wetting?	yes / no
11. Ever been dizzy during or after exercise?	yes / no	26. Have problems with sleepwalking?	yes / no
12. Ever had seizures?	yes / no	27. Ever had emotional difficulties for which professional help was sought?	yes / no
13. Ever had chest pain during or after exercise?	yes / no		yes / no
14. Ever had high blood pressure?	yes / no	28. Ever had an eating disorder?	yes / no
15. Ever had back problems?	yes / no	29. Ever been diagnosed with a heart murmur?	yes / no

Please explain any "yes" answers, noting the number of the questions. For more specific health conditions (i.e. Diabetes mellitus, unstable or newly diagnosed asthma, seizure disorders) please provide more specific health information from the physician regarding the condition.

Mental, Emotional, and Social Health:
Has the camper:
1. Ever been treated for attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD).....yes / no
2. Ever been treated for emotional or behavioral difficulties or an eating disorder?..... .....yes / no
3. During the past 12 months, seen a professional to address mental/emotional health concern .....yes / no
4. Had a significant life event that continues to affect the camper's life?.....yes / no
(history of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)

Please explain "yes" answers in the space below, noting the number of the questions. The camp may contact you for additional information

Medications/Standing Orders/Immunizations

Must be completed by a health care provder. "Medication" is any substance a person takes to maintain and/or improve their health. This incudes vitamins and natural remedies. Any medication your child may need must be given to our medical director in the original prescription bottle. This medicine can only be dispensed according to the doctor's written instructions. Be sure to provide enough of each medicine to last the entire time the camper will be at camp.

Medication: ☐ This camper will not take any daily medications while attending camp.
☐ This camper will take the following daily medications(s) while at camp:

Name of medication	When it is given	Dosage	How it is given	Comments
	☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other			
	☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other			
	☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other			
	☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other			

The following non-prescription medications may be stocked in the camp Health Center and are used on an as-needed basis to manage illness and injury (to be administered at the discretion of RN).

Drug	Dosage	Schedule	Provider Order	Comments	MD signature/ Initials
Acetaminophen (Tylenol)	Per label instructions by age/weight	q 4hr prn for pain or fever >_____	Yes / No		
Ibuprofen	Per label instructions by age/weight	q 4hr prn for pain or fever >_____	Yes / No		
Antihistamine/ allergy medicine (Benadryl)	Per label instructions by age/weight	q 4hr prn for pain or fever >_____	Yes / No		
Calamine Lotion	Per label Instructions	For insect bites, poison ivy, itching	Yes / No		
Insect repellent	Per label Instructions	Preventative	Yes / No		
Sunscreen	Per label Instructions	Preventative	Yes / No		
1%Hydrocotozone cream	Per label Instructions	For insect bites, poison ivy, itching	Yes / No		
Pseudoephedrine decon-gestant (Sudafed PE)	Per label instructions by age/weight	q 4hr prn for pain or fever >_____	Yes / No		
Generic cough drops	Per label instructions	For sore throats and coughing	Yes / No		
Antibiotic cream	Per label Instructions	For avoiding infection in cuts, and open sores	Yes / No		
Tums, Rolaids & antacids....	Per label Instructions	For Upset stomach Ingestion problems	Yes / No		
Pepto-Bismol	Per label instructions by age/weight	For upset stomach, ingestion problems	Yes / No		

Immunization History: Please provide the month and year for each immunization. Starred (*) immunizations must be current. Copies of immunization forms from health-care providers or state or local government are acceptable. Please attach to this form.

Immunization	Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most Recent Dose Month/ Date
Diphtheria, Tentanus, Pertussis * (Dtap) or TdAP)						
Tetanus booster* (dT) or (Tdap)						
Mumps, Measles, Rubella* (MMR)						
Polio* (PV)						
Haemophilus Influenza type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (Chicken pox) □ Had chicken pox						
Meningococcal meningitis (MCVA)						

Tuberculosis (TB) test	Date:	□ Negative	□ Positive

If your camper had NOT been fully immunized please sign the following statement: I understand and accept the risks to my child from not being fully immunized.

Signature of Custodial
Parent/Guardian: _____ Date: _____

Physicians Name (printed): _____

Signature of physician: _____

Date _____ Phone Number _____

Name of family Dentist/Orthodontist _____ Phone Number _____

Parent/Guardian Authorization for Health Care:
This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

Signature of Custodial
Parent/Guardian _____ Date: _____