Camper Medical Form

Please bring this form and immunization records with you on the day you come to camp.

This form MUST have both physician's and parent's signature. To fax this form, use 833-536-5341.

Camper's Name: ______________________________ Birth date:______________ Age:__________

Address:____Phone:____________________

Street and number City/Town State Zip

Custodial Parent/Guardian:________________________________Home/Cell: ________________

Parent Address (if not same as above)______________________Business Phone:_____________

If not available, in an emergency please notify:

Name & Relationship:_____________________________________Home phone: _______________

Address:____Cell: _______________________

Street and number City/Town State Zip

PHYSICAL HEALTH HISTORY: To be filled out by a parent *within 1 month prior to arrival at camp.*

(Check any that apply)		
☐ Asthma	☐ Seizures and/or Epilepsy	☐ Frequent Ear Infections
☐ Bleeding/Clotting Disorder	☐ Emotional/Behavioral Disorder	☐ Diabetes
☐ Heart defect/disorder	☐ Frequent Bed Wetting	☐ Recent Injury
Allergies		
☐ Bees or Insect Bites/Stings	☐ Food (Specify)	☐ **Carries Epipen**
☐ Penicillin	☐ Other (Specify)	

I authorize my child to carry and use insect repellents, and for Camp personnel to assist in its application if necessary. ☐ Yes ☐ No

MENTAL, EMOTIONAL AND PSYCHOLOGICAL HEALTH HISTORY: (check yes or no)

1. This camper has an emotional health concern that will impact camp participation ☐ Yes ☐ No
2. This camper has a psychiatric diagnosis such as depression, OCD, panic/anxiety disorder ☐ Yes ☐ No
3. This camper has had a significant life event that continues to affect the camper's life/health ☐ Yes ☐ No
4. This camper uses an individualized learning plan (IEP) at school ☐ Yes ☐ No

***If "yes" was the answer to any of the four statements above, *please attach a statement* from a parent or the professional involved that includes the following with regard to the child's participation at camp:

A. Description of the concern and the camper's management plan (including medications) while at camp:
B. Description of the behaviors that will indicate to our staff that your camper needs medications and/or professional referral and provides a recommendation from this professional supporting your child's participation in our camp.

Meningococcal Meningitis Vaccination: I have read, or have had explained to me, information regarding this disease and vaccination. I understand that the vaccine's protection lasts for approximately 3-5 years and that revaccination may be considered within 3-5 years.

Must check one box for attendance

☐ The participant has had the Meningococcal Meningitis immunization within the last 10 years. Date received: ________

☐ I understand the risks of not receiving the vaccine. I have decided that the participant will not obtain immunization against Meningococcal Meningitis disease.

IMMUNIZATION RECORDS: Please attach *an up to date copy of physician's immunization record (*required by NYS law for each camper and must be updated annually). A complete record shall include immunization dates against diphtheria, haemophilus influenza type b, hepatitis b, measles, mumps, poliomyelitis, rubella, chicken p o x , tetanus and meningitis.

☐ **Not Immunized (Must sign a waiver)**

RELEASE FOR MEDICAL TREATMENT OF A MINOR:

☐ The health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities, except as noted by the medical provider and myself. I acknowledge residential camp experience may expose the camper to communicable diseases. I hereby authorize the camp personnel to handle any medical problem with my child during his or her stay at camp including contacting the family doctor for more information. I grant the release of any records necessary for treatment, referral, billing or insurance purposes. In case of emergency, after every reasonable effort is made to contact the parent/guardian, permission hereby is given to the physician selected by the camp to provide proper treatment. Expenses incurred for medical needs of the camper are the responsibility of the parent.

PARENT AUTHORIZATION: This statement MUST be signed in order for camper to attend camp.

Parent/Guardian Signature:____________________________________Date: ______________

Insurance Carrier: ____

Plan number/Group number:___________________________ID Number: _________________

Camp JYC provides the following generic **over the counter medications and campers do not need to supply them**. Parent and Doctor must indicate which medications may be administered while the child is at camp. Only medications marked "YES" and determined to be necessary will be administered at the discretion of the camp nurse. Medications will be dispensed "per label directions" unless otherwise specified.

Medication Name (or generic equivalent)	**YES**	**NO**	**Comments (specific instructions for dosage)**
Tylenol (Acetaminophen; for fever or pain)			
Advil/Motrin (Ibuprofen; for fever or pain)			
Benadryl (for allergic reactions)			
Calamine or Caladryl Lotion (for insect bites)			
Tums (or equivalent antacid)			
Triple Antibiotic Ointment (for minor cuts/scratches)			
Other:			
Other:			

MEDICATION INFORMATION: ALL medications including prescriptions, over the counter medications, herbal remedies, and dietary supplements must be kept and administered by the camp nurse. Self-carry emergency medications (inhalers, epi-pen) require prescription and prior approval from the camp nurse. Any camper found to be self-administering ANY medication could be grounds for dismissal from camp.

Below you must list all medications that will be brought to camp with this camper. This list MUST include all prescriptions, over the counter medications, herbal remedies, and dietary supplements!

Name of Medication/Dosage/Frequency　　　　Reason for Taking

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- PRESCRIPTION DRUGS MUST BE IN ORIGINAL CONTAINERS WITH PHARMACIST'S LABEL, CAMPER'S NAME AND A **SIGNED SCRIPT FROM THE DOCTOR**
- ANY OTHER MEDICATIONS/VITAMINS MUST BE IN ORIGINAL CONTAINERS AND LABELED WITH CAMPER'S NAME AND DIRECTIONS FOR USE.
- IF MEDICATION MUST BE TAKEN ON A TIME SCHEDULE, PLEASE INCLUDE SPECIFIC INSTRUCTIONS WITH TIMES INCLUDED.

MEDICAL EVALUATION: To be completed by a Licensed Physician/Nurse Practitioner/PA

It is my opinion that the participant____is____is not able to participate in an active camp program.

The participant is under the care of a physician for the following conditions: (Please include any medications and describe any restrictions including any activities the participant should be exempt from.)

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Name of Physician and title ____

Signature of Physician ______________________________________ Date______________

Address____ Phone________________