Camper Medical Form

SUMMER 2017

The information on this form is not part of the camper acceptance process but is gathered to assist us in identifying appropriate care. Health history (first three pages) must be filled out by parents/guardians. Page 4 to be completed by Physician.

Mail this form to the address below by 5/1/17

MOUNT TOM DAY CAMP
48 Mount Tom Road
New Rochelle, NY 10805
Fax #: 914-576-3270

Gender: ☐ Male ☐ Female

Name_____ Birth date_____ Age at camp_____
Last First Middle

Home address_____
Street address City State Zip

Custodial parent/guardian_____ Cell Phone_____

Home address_____ Home Phone_____
(if different from above) Street address City State Zip

Business address_____ Bus Phone_____
Street address City State Zip

Second parent / guardian / emergency contact_____ Cell Phone_____
(please circle one)

Address_____ Home Phone_____
Street address City State Zip

Business address_____ Bus Phone_____
Street address City State Zip

If above not available in an emergency, notify:

Name_____ Cell Phone_____

Relationship_____ Day Phone_____

Address_____
Street address City State Zip

Insurance Information

Is the participant covered by family medical/hospital insurance? ☐ Yes ☐ No

If so, indicate carrier or plan name_____ Group #_____ Tele #_____

ALLERGIES List all known. Describe reaction and management of the reaction.

Medication allergies (list)

_____ _____
_____ _____
_____ _____

Food allergies (list)

_____ _____
_____ _____
_____ _____

Other allergies (list) – include insect stings, hay fever, asthma, animal dander, etc.

_____ _____
_____ _____
_____ _____

Use this space to provide any additional information about the participant's behavior, physical, emotional, or mental health about which the camp should be aware. Please be assured that all information provided on this form will be kept confidential.

_____

_____

_____

ALL MEDICATIONS BEING TAKEN

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely.

□ This person takes NO medications on a routine basis.

□ This person takes medications as follows:

Med #1_____ Dosage_____ Specific times taken each day_____

Reason for taking_____

Med #2_____ Dosage_____ Specific times taken each day_____

Reason for taking_____

Med #3_____ Dosage_____ Specific times taken each day_____

Reason for taking_____

Attach additional pages for more medications.

Identify any medications taken during the school year that participant does/may not take during the summer:_____

_____

MEDICATIONS ADMINISTERED DURING CAMP

• Must be accompanied by a doctor's written order • Keep in original packaging/bottle that identifies the prescribing physician (if prescription drug), the name of the medication, dosage, and frequency of administration • Please provide sufficient medications for entire camp session • All medications will be administered/stored by camp nurse

RESTRICTIONS

The following restrictions apply to this individual.

Dietary

□ Does not drink milk □ Does not eat red meat □ Does not eat fish
□ Does not eat ice cream □ Does not eat poultry □ Does not eat eggs
□ Does not eat other dairy products
□ Other (describe)_____

Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary)

_____

_____

_____

_____

General Questions (Explain "yes" answers below)

Has/does the participant:	Yes	No
1. Had a recent injury, illness or infectious disease?	□	□
2. Have a chronic or recurring illness/condition?	□	□
3. Ever been hospitalized?	□	□
4. Ever had surgery?	□	□
5. Have frequent headaches?	□	□
6. Ever had a head injury?	□	□
7. Ever been knocked unconscious?	□	□
8. Wear glasses, contacts, or protective eyewear?	□	□
9. Ever had frequent ear infections?	□	□
10. Ever passed out during or after exercise?	□	□
11. Ever been dizzy during or after exercise?	□	□
12. Ever had seizures?	□	□
13. Ever had chest pain during or after exercise?	□	□
14. Ever had high blood pressure?	□	□
15. Been diagnosed with a heart murmur?	□	□
16. Ever had back problems?	□	□
17. Ever had problems with joints (e.g. knees, ankles)?	□	□
18. Have an orthodontic appliance being brought to camp?	□	□
19. Have any skin problems (e.g. itching, rash, acne, eczema)?	□	□
20. Have diabetes?	□	□
21. Have asthma?	□	□
22. Had mononucleosis in the past 12 months?	□	□
23. Had problems with diarrhea/ constipation?	□	□
24. If female, have an abnormal menstrual history?	□	□
25. Ever had an eating disorder?	□	□
26. Ever had emotional difficulties for which professional help was sought?	□	□

Please explain any "yes" answers, noting the number of the questions.

_____

_____

_____

_____

_____

Date of last medical examination: _____

Which of the following has the participant had?

- ☐ Measles
- ☐ Chicken pox
- ☐ German measles
- ☐ Mumps
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C

TB Mantoux Test
Date of last test_____
Result: ☐ Positive ☐ Negative

Please give all dates of immunization for (or attach immunization form from M.D.)

Vaccine:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP	_____	_____	_____	_____	_____	_____
TD(tetanus/diphtheria)	_____	_____	_____	_____	_____	_____
Tetanus	_____	_____	_____	_____	_____	_____
Polio	_____	_____	_____	_____	_____	
MMR	_____	_____				
or Measles	_____	_____				
or Mumps	_____	_____				
or Rubella	_____	_____				
Haemophilus influenza B	_____	_____	_____	_____		
Hepatitis	_____	_____	_____			
Varicella (chicken pox)	_____	_____				

Name of family physician_____ Phone_____

Address_____

Name of family dentist/orthodontist_____ Phone_____

Address_____

Parent/Guardian Authorization

This health history is correct and complete as far as I know. 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 over the counter and/or prescribed medications with doctor's orders only, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to the camp to arrange necessary related transportation for my child.

I consent to have my child use sunscreen s/he has brought to camp and is approved by the FDA for over the counter use to avoid overexposure to the sun. My child may be assisted by camp staff if s/he requests.

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 with the understanding that the family will be notified as soon as possible. This completed form may be photocopied for trips out of camp.

I also understand and agree to abide by any restrictions placed on my child's participation in camp activities.

Signature of parent/guardian _____

Printed name_____ Date_____

Health Care Recommendations by Licensed Medical Personnel

I examined the individual on _____. (Exam must be within past 18 months of camp attendance)

BP_____ Weight_____ Height_____

In my opinion, the above applicant □ is □ is not able to participate in an active camp program.

The applicant is under the care of a physician for the following conditions:

_____

_____

_____

_____

Recommendations and Restrictions at Camp

Treatment to be continued at camp

_____

_____

Medications, including over-the-counter, to be administered at camp (name, dosage, frequency); **MUST BE ACCOMPANIED BY A DOCTOR'S WRITTEN ORDER.**

_____

_____

Any medically-prescribed meal plan or dietary restrictions

_____

_____

Known allergies

_____

_____

Description of any limitation or restriction on camp activities

_____

_____

Additional information for health care staff at the camp

_____

_____

Signature of Licensed Medical Personnel_____
Printed_____ Title_____
Address_____
Phone_____ Date_____

For camp use only

Screening Record
Date screened_____
Meds received_____
_____
Updates/additions to health history noted □ Yes □ No □ None required
Current health needs identified_____
_____
Observational notes_____
_____
Screened by_____