Camp Herrlich
Summer 2015

101 Deacon Smith Hill Road
Patterson, NY 12563
(ph) 845-878-6662 (fax) 845-878-2030
healthcenter@campherrlich.org
www.campherrlich.org

REQUIRED MEDICAL HISTORY

(Parent or Legal Guardian to Complete)

Please Check One: ( ) Day Camper ( ) Sleepaway Camper ( ) Staff

Session (Please be specific):

Camper Name _____ **Date of Birth:** _____
Address_____ **Phone#:** _____
_____

Emergency Notification:

With whom does child reside and what is / are his / her relationship(s) with the child?_____
Parent 1 Name_____ Phone: Home _____ Work _____ Cell _____
Parent 2 Name_____ Phone: Home _____ Work _____ Cell _____
Person to contact in an emergency if parents are unavailable:
Name:_____ Phone: Home_____ Work_____ Cell _____
Physician:_____Phone:_____ Fax:_____
Dentist/Orthodontist:_____ Phone_____

Emergency Medical Information (check yes or no)

Yes___ No___ Allergy to a medicine, food, plant, animal, or insect
Yes___ No___ Do you have an epinephrine pen?
Yes___ No___ Any condition that requires special care, medication or diet
Yes___ No___ Asthma
Yes___ No___ Contact Lenses
Yes___ No___ Seizure Disorder
Yes___ No___ Diabetes ____ Type 1____Type 2
Yes___ No___ Heart Trouble
Yes___ No___ Bleeding Disorder
Yes___ No___ Dentures
Yes___ No___ Bonded Teeth

Explain any of the above:_____

Medical History (check yes or no)	**Yes**	**No**	**Date**	**Details**
Serious illness	_____	_____	_____	_____
Serious injury	_____	_____	_____	_____

Does your child have frequent: (circle yes or no)

Y / N Eye Infections **Y / N** Respiratory Infections
Y / N Ear Infections **Y / N** Urinary Tract Infections
Y / N Throat Infections **Y / N** Vaginal Infections

Does your child have: (circle yes or no)

Y / N Heart Murmur **Y / N** Menstrual Problems
Y / N Rheumatic Fever **Y / N** Hernia
Y / N Stomach/Intestinal Problems **Y / N** Back or Joint Pains

Explain any of the above:_____
Has this person had Chicken Pox? ( ) Yes ( ) No If yes, when? Date_____
Has this person had Mumps? ( ) Yes ( ) No If yes, when? Date _____
Has this person been exposed to a contagious disease within the past three weeks? _____
Has this person had lice in the past six months? _____
If applicable, has this person started menstruation? ( ) Yes ( ) No Has she been told about menstruation? ( ) Yes ( ) No
Does this person take any medication (including prescription, over the counter medication, inhalers, epi-pen, etc.)? Yes* ___ No ____
Explain:_____
***IF YES, PAGE 2 OF THE MEDICAL EVALUATION FORM MUST BE COMPLETED BY THE DOCTOR OR THE CHILD CANNOT TAKE THEIR MEDICATION AT CAMP!**

To the best of my knowledge, the above information is correct. I give my child permission to participate in all camp activities and trips.
In the event of accident or illness, I authorize the Camp to institute and obtain medical care.
**** In the event of a communicable disease outbreak, I understand this person will be excluded from camp if not fully immunized.**

DATE_____ **SIGNATURE (parent or legal guardian)**_____

Family Insurance Information: Please send a copy of both the front and back of all Health Insurance and Prescription Cards so they can be submitted at time of service to save you money.

Policy Holder_____ Carrier_____
Policy Number_____ Address_____
Does this policy include dental coverage? Yes_____ No_____

Camp Herrlich, Patterson, NY

MEDICAL EVALUATION

(To be completed by physician)

Name_____Date of Birth_____ has had a complete history and physical exam on_____
Month/Day/Year Month/Day/Year

Screening / Test Results

Height:	**BMI:**	**Vision/Type of Screening**
Weight:	☐ Normal	With Glasses R 20 / L 20 /
Blood Pressure:	☐ Abnormal	With out Glasses R 20 / L 20 /
Pulse:	Min:	
HCT/Hgb:	Slight:	**Auditory /Type of Screening**
Urinalysis:	Mod:	Right Pass / Fail
Gross Dental:	Marked:	Left Pass / Fail
Lead (Date/Result):	☐ Referral to:	

TB: In high-risk group? ☐ yes ☐ no		
TB & other Test Results: (Sickle Cell, etc.)		
Test	**Date**	**Result**

Disease Assessment

Yes	No			Date of Onset
☐	☐	Asthma	☐ Mild ☐ Moderate ☐ Severe ☐ Exercise Induced ☐ Unclassified	
☐	☐	Diabetes	☐ Type I ☐ Type II	
☐	☐	Anaphylactic Reaction	☐ Food ☐ Insect ☐ Latex ☐ Other: Explain	
☐	☐	Seizure Disorder	Type:	
☐	☐	Chicken Pox	If yes, when?	
☐	☐	Mumps	If yes, when?	
☐	☐	Other: Please Specify		

Immunization History

(Please provide month, day and year of immunization)

Vaccine	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DPT / Hib						
DTaP						
DT / Td						
OPV						
IPV						
MMR						
HiB						
Hep B						
Hep A						
Varicella						
TDap						
PCV						
HPV						
MCV						
Influenza						

****If a child is on medication (including vitamins, over-the-counter medicine, Epi-Pens, Inhalers, etc.) for ANY reason, the next two pages MUST be filled out by the physician. If it is not, the child WILL NOT BE GIVEN THEIR MEDICATION AT CAMP!****

Child's Name: _____

Prescription Medication: Please complete with patient's current regimen for both scheduled and PRN medications; please use additional paper if needed. If child is diabetic, please include Doctor's orders on a separate page.

DRUG	ROUTE	DOSAGE	FREQUENCY	COMMENTS

Emergency Medications:

Does this person require: **Epi-pen:** □ yes □ no **PRN Inhaler:** □ yes □ no

This person has permission to carry: **Epi-pen:** □ yes □ no **PRN Inhaler:** □ yes □ no

(Note: ability to carry implies ability to self administer)

Additional Orders: As deemed necessary by health care provider to be implemented by an R.N. (i.e. dressing changes, cast care, etc.):

_____

_____

_____

Limitations on Activities:

Swimming_____ Hiking_____Athletics_____Other:_____

Explain above:_____

I certify that I have on this date examined the above named camper and that on the basis of my examination and the medical history as furnished to me, I have found no reason which would make it medically inadvisable for this camper to participate in physically strenuous activities.

Signature of Physican_____Date of Examination_____

Please Print: Physician's Name_____License# _____

Address_____ Phone#_____

Sunscreen Permission: TO BE SIGNED BY PARENT

I give permission for Camp Herrlich staff members to apply or aid in applying sunscreen to my child. I will send the sunscreen to Camp Herrlich clearly labeled with my child's name. I also certify that this product is FDA approved and that I have tested this product on my child with no adverse reactions. Camp Herrlich will be held harmless for any reaction due to application of sunscreen I provide.

If you have sunscreen requirements or a schedule for application, please tell us here:

_____

Parents Signature: _____Date: _____

HIPPA Privacy Statement: Permission to Release Confidential Health Information

I give _____permission to release confidential health information to Camp Herrlich
Name of Medical Practice

regarding this person_____
Name of Camper or staff member

Date:_____ Parents/Guardian Signature:_____

Camper Name:_____ **Date of Birth:**_____

Standard Over the Counter Medications:

The following medications are available in the Health Center and will be administered at the discretion of the Health Director, PRN only with **Physician's Order** and **Parental Permission**. Please complete dosage and schedule for medications which can be given to participant.

DRUG NAME	ROUTE	DOSAGE	SCHEDULE	INDICATIONS	COMMENTS
IBUPROFEN	PO	____MG ___ML	Q___HRS	PAIN, FEVER, COLD SX,TOOTHACHE, MUSCLE ACHES	
ACETAMINOPHEN	PO	____MG ___ML	Q___HRS	PAIN, FEVER, COLD SX,TOOTHACHE, MUSCLE ACHES	
PSEUDOEPHDRIN & IBUPROFEN (ADVIL COLD & SINUS)	PO	____MG ___ML	Q___HRS	PAIN, FEVER , NASAL CONGESTION	
ROBITUSSIN	PO	____MG ___ML	Q___HRS	COUGH	
COUGH DROPS & LOZENGES	PO	____MG ___ML	Q___HRS	COUGH, SORE THROAT	
DIPHENHYDRAMINE	PO	____MG ___ML	Q___HRS	INSECT BITES, ALLERGIES, RESPIRATORY ALLERGIES	
PSEUDOEPHEDRINE	PO	____MG ___ML	Q___HRS	NASAL/SINUS CONGESTION, HAY FEVER, ALLERGIES	
ANTACID	PO	____MG ___ML	Q___HRS	GAS, HEARTBURN, INDIGESTION, STOMACH UPSET	
MILK OF MAGNESIA	PO	____ML	AT BEDTIME		
IVY BLOCK and TECNU	TOPICAL		APPLY__X PER DAY	CONTACT WITH POISON IVY	
CALAGEL, CALAMINE, AND HYDROCORTISONE	TOPICAL		APPLY__X PER DAY	INSECT BITES, RASH, SKIN IRRITATION	
PEROXIDE	TOPICAL		APPLY__X PER DAY	CUTS, SCRAPES, SPLINTERS, BLISTERS	
BACITRACIN	TOPICAL		APPLY__X PER DAY	CUTS, SCRAPES	
ANTIFUNGAL CREAM/SPRAY	TOPICAL		APPLY__X PER DAY	ATHLETES FOOT, JOCK ITCH	
COOLING GEL and ALOE	TOPICAL		APPLY__X PER DAY	BURNS, SUNBURN, WIND BURN	
MUSCLE RUB	TOPICAL		APPLY__X PER DAY	MINOR MUSCLE STRAINS OR PAINS	
ORASOL, AMBESOL and ABREVA	TOPICAL		APPLY__X PER DAY	ORAL HERPES, COLD SORES, TOOTHACHE	
MEDICAINE	TOPICAL	1 SWAB	APPLY ONCE	INSECT STINGS	
VISINE	OPTICAL	___DROPS	APPLY__X PER DAY	EYE STRAIN, EYE IRRITATION	

Doctor's Signature:_____

Parental/Guardian Signature:_____

Update to Health Form

Child's Name: _____Date: _____

Please note any changes to medication since the "Required Medical History" forms were submitted. Be sure to note changes in dose (strength or number of mgs) or the number of times per day that a medicine is taken even of medicines that were on the original health form.

Any changes must be signed for by the prescriber!

Medication Name	Dose	Frequency	Route

Remember camper can not receive vitamins, supplements, herbal preparations or homeopathic remedies without a prescription.

Note any changes in the campers physical or medical condition since the original health form was submitted.

Medical Change or Condition:

Date of Onset: _____ Condition; _____
Date of Onset: _____ Condition; _____
Date of Onset: _____ Condition; _____
Date of Onset: _____ Condition; _____
Date of Onset: _____ Condition; _____

Consent of Physician:

Signature of Physican_____Date of Examination_____

Please Print: Physician's Name_____License# _____

Address_____ Phone#_____

Consent of Parent/Guardian:

Parents Signature: _____Date: _____