

Camper Health History/Physical Exam Form

(NOT NEEDED FOR FAMILY CAMPS)

Fill in all requested information. Incomplete forms cannot be processed and will be returned. Forms are due two (2) weeks before your Child's session begins

Camper Name _____

Physical Examination - To be filled out by a licensed healthcare provider *New York State law requires a signed/dated physical exam, within the last 12 months and dates of most current boosters*

Immunization History - Must be completed with dates or enclose a copy. Please record the date (month and year) of basic immunizations and most recent booster doses:

DPT or DT Tuberculosis Other tetanus Hepatitis vaccination Chicken Pox Vaccine
 MMR Polio vaccine (most recent) Pneumonia vaccination Recent exposure to contagious disease Flu vaccine

General Condition or Appraisal

Birthdate _____	Nutrition _____	Allergy _____	Athlete's foot _____
Height _____	Nose _____	Foods _____	Impetigo _____
Weight _____	Throat-tonsils _____	Drugs _____	Infection _____
Posture & Spine _____	Lungs _____	Other _____	Pediculosis _____
Feet _____	Eyes _____	Abdomen _____	Describe Current conditions (diabetic, seizures, emotional issues, etc.) _____
Teeth _____	Discharge _____	Genitals _____	_____
Blood pressure _____	Glasses _____	Hernia _____	_____
Heart murmur _____	Menstruation _____	Skin _____	_____
Ears _____	Urine _____	Scabies _____	_____

Standard Over the counter/PRN medications: (The following medications are available in the infirmary and will be administered at the discretion of an RN, if approval is indicated by the camper's healthcare provider)

Drug Name	Route (indicate formulation[s])	Dosage	Schedule & Indications	Healthcare Provider Initials	Comments
Sunburn Spray/Lotion/Aloe-Gel	Topical	To affected site	2-3 times daily (prn)		
Acetaminophen (Tylenol)	PO (chewable tabs, elixir, tabs)	Per label instr. by age/weight	Q 4 hr prn for pain or fever > _____ °F		
Ibuprofen (Motrin)	PO (chewable tabs, elixir, tabs)	Per label instr. by age/weight	Q 6 hr prn for pain or fever > _____ °F		
Diphenhydramine Hydrochloride (Benadryl)	PO (chewable tabs, elixir, tabs)	Per label instr. by age/weight	Q 6 hr prn for allergic reaction (hives, insect bite)		
Hydrocortisone Cream or Benadryl Cream	Topical	Per label instr. by age/weight	prn - itching		
Bismuth Subsalicylate (Pepto-Bismol)	PO (Liquid or chewable tabs)	Per label instr. by age/weight	Q 30 min to 1 hr prn for diarrhea (no>8 doses/24 hr)		
Loperamide HCl (Immodium)	Tab or liquid	Per label instr. by age/weight (max of 8 mg/24 hr)	Per episode/ max 8 mg/24 hr		
Tums	Chewable tab	Per label instr. by age/weight	No>10 tabs/24 hrs		
Throat Lozenges/Cough Drops	Tab	1 Lozenge	No>6/24 hr		

Prescription Medications (please complete with patient's current regimen for both scheduled and prn medications)

Drug	Route	Dosage	Schedule & Information	Comments

Additional Orders (as deemed necessary by healthcare provider to be implemented by an RN (i.e. peak flows, dressing changes, cast care, etc.))

I believe this child is able to attend camp and participate in all camp activities with the following restrictions and recommendations (attach specific instructions or medications, treatments and diet, restrictions or considerations):

Provider's Name (print) _____
 Providers Signature _____
 Address: _____

License #: _____
 Date: _____
 Phone: _____

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Mail to: **Camp Cherokee, c/o New York Conference of SDA, 4930 W. Seneca Tpk., Syracuse, NY 13215**

Please Print (THIS SIDE AND TOP OF BACK PAGE TO BE FILLED IN BY PARENT BEFORE PHYSICAL EXAMINATION).

Camper Name _____ Birth date: _____ Age _____ Sex _____ Home Phone _____
 Parent/Guardian _____ Home Address _____
 Business Address _____ Business/Cell Phone _____
 Other Parent/Guardian _____ Home Address: _____ Home Phone _____
 Business Address _____ Business/Cell Phone _____
 In the event of emergency, and parent or guardian cannot be reached, notify _____ Relationship to camper _____
 Address _____ Home Phone _____ Business/Cell Phone _____

Note:
 This person must be a relative over 18. If someone is not a relative, a "notarized statement" authorizing that person to approve medical treatment is necessary. In the event of an injury or illness that does not require removal to a hospital, parents shall not be notified unless medical personnel's concerns dictate. When injuries or illnesses require a trip to the hospital, either the RN accompanying the camper or the camp director or their designee will notify the parents.

Health History - To be completed by **PARENT/GUARDIAN** (give approximate date of illness or "no" if not applicable)

<input type="checkbox"/> frequent ear infections	<input type="checkbox"/> hypertension	<input type="checkbox"/> bleeding/clotting	<u>Allergies</u>	<u>Diseases</u>
<input type="checkbox"/> heart defect/disease	<input type="checkbox"/> psychiatric treatment	<input type="checkbox"/> bed wetting	<input type="checkbox"/> hay fever <input type="checkbox"/> other	<input type="checkbox"/> chicken pox
<input type="checkbox"/> convulsions	<input type="checkbox"/> mononucleosis	<input type="checkbox"/> fainting	<input type="checkbox"/> plants <input type="checkbox"/> insect stings	<input type="checkbox"/> measles
<input type="checkbox"/> diabetes	<input type="checkbox"/> sleep walking	<input type="checkbox"/> asthma	<input type="checkbox"/> food: _____	<input type="checkbox"/> German measles
				<input type="checkbox"/> mumps

Medication Allergies: _____
 Current medication (send in original container with instructions): _____
 Operations or serious injuries (dates): _____ Disability of chronic or recurring illness: _____
 Dietary modifications: _____ Any specific activities limited: _____
 Name of dentist/orthodontist: _____ Phone: _____
 Name of family physician: _____ Phone: _____

Medical Insurance

Policy Holder's Name	Name of insurance carrier and type of coverage	Policy No.	Group No.
Authorization for release for information to above named insurance carrier Signature _____ Date _____ Relationship to camper (parent, etc.) _____			
Address of Insurance Company			

Your personal medical policy is your child's primary coverage. All campers must have medical insurance to attend camp. All registered campers are covered by excess coverage accident insurance while at camp.

IMPORTANT - This Box Must Be Completed For Attendance

This 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. Authorization for treatment: I hereby give permission to the medical personnel selected by the camp director to order x-rays, routine test, treatment and necessary transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp Director to secure and administer treatment, including hospitalization, for my child, as named above. The completed forms may be photocopied for trips out of camp.

Meningococcal Meningitis Vaccination Response

New York State Public Health Law requires the operator of an overnight children's camp to maintain a completed response for every camper who attends camp for seven (7) or more nights. Please check one box and sign below.

My child has had the meningococcal meningitis immunization (Menomune™) within the past 10 years. Date received: _____
Note: The vaccine's protection lasts for approximately 3 to 5 years. Re-vaccination may be considered within 3-5 years)

I have read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that my child will **not** obtain immunization against meningococcal meningitis disease.

Signature of parent or guardian _____

I also understand and agree to abide with the restrictions placed on my camp activities.

Signature of minor _____