DOROTHY P. FLINT NASSAU COUNTY 4-H CAMP **Session (s)** _____

HEALTH INFORMATION— TO BE COMPLETED BY PARENT/GUARDIAN

NEW YORK STATE requires camps to have a completed health form for each child.

CAMPER'S NAME _____ _____ _____ _____ _____ _____
Last *First* *Middle* *Birth Date* *Age* *Gender*

Parent or Guardian _____

Home address _____
Number and Street *City/State* *Zip+4*

Phone ( ) _____ ( ) _____ ( ) _____
Day *Evening* *Cell*

Other Parent or Guardian _____

Phone ( ) _____ ( ) _____ ( ) _____
Day *Evening* *Cell*

IF PARENT OR GUARDIAN CANNOT BE REACHED, NOTIFY _____
Must be over 18 years of age

Relationship to Camper _____

Phone ( ) _____ ( ) _____ ( ) _____
Day *Evening* *Cell*

MEDICAL INSURANCE Fill out completely OR attach a copy of your medical insurance card (front and back).

Policy Holder's Name	Name of Insurance carrier and type of coverage	Policy Number	Group Number

Authorization for release of 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 **Please notify the camp office if this camper is exposed to any communicable disease during the three weeks prior to camp attendance.**

PERMISSION TO PROVIDE NECESSARY TREATMENT OR EMERGENCY CARE

I certify that the information given in this form and on the attached immunization record is current and correct. I hereby give permission to the medical personnel selected by the Camp Coordinator to order x-rays, routine tests, treatment, release any records necessary for insurance purposes, and to provide or arrange for necessary transportation for my child. In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the Camp Coordinator to secure and administer treatment, including hospitalization, for the person named above. This form may be photocopied for trips out of camp.

SIGNATURE OF PARENT OR GUARDIAN: _____

Dec 2016

CAMPER'S NAME _____
Last Name *First Name*

1 2 2S 3 3S 4 5 5S 6 6S 7 7S 8

HEALTH INFORMATION— TO BE COMPLETED BY PARENT/GUARDIAN

FILL IN ALL REQUESTED INFORMATION. INCOMPLETE FORMS CANNOT BE PROCESSED AND WILL BE RETURNED.

CAMPER'S NAME _____ **First time overnight camper?** ☐ Yes ☐ No

(Check YES or NO)

☐ Yes	☐ No	asthma
☐ Yes	☐ No	frequent ear infections
☐ Yes	☐ No	heart defect/disease
☐ Yes	☐ No	convulsions
☐ Yes	☐ No	diabetes
☐ Yes	☐ No	bleeding/clotting disorders
☐ Yes	☐ No	hypertension
☐ Yes	☐ No	psychiatric treatment
☐ Yes	☐ No	mononucleosis
☐ Yes	☐ No	bedwetting
☐ Yes	☐ No	fainting
☐ Yes	☐ No	eating disorder
☐ Yes	☐ No	sleepwalking
☐ Yes	☐ No	headaches

Operations or serious injuries (dates): _____

Disability or chronic medical conditions: _____

Current medication (send in original container with instructions): _____

Dietary modifications: _____

Any specific activities to be limited: _____

Name of family physician: _____

Phone: ( ) _____

Allergies

☐ Yes	☐ No	medications _____
☐ Yes	☐ No	foods _____
☐ Yes	☐ No	insect stings _____
☐ Yes	☐ No	poison ivy
☐ Yes	☐ No	hay fever

Diseases

☐ Yes	☐ No	chicken pox
☐ Yes	☐ No	measles
☐ Yes	☐ No	German measles
☐ Yes	☐ No	mumps

MENINGOCOCCAL MENINGITIS VACCINATION

New York State Public Health Law requires the operator of an overnight children's camp to maintain a completed response form for every camper who attends camp.

REQUIRED—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. Revaccination may be considered within 3 to 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.

☐ Please refer to immunization record

SIGNATURE OF PARENT/GUARDIAN _____

REQUIRED SIGNATURES

I have read and discussed the 2016 Parent-Camper Handbook with my child. We agree to abide by all policies and procedures contained therein.

SIGNATURE OF PARENT/GUARDIAN _____

SIGNATURE OF CAMPER _____

CAMPER'S NAME _____

PHYSICIAN 1

Mandatory to be completed by a licensed physician

PHYSICAL EXAMINATION & HEALTH HISTORY

IMMUNIZATION HISTORY

You MUST record the specific date (month and year) of basic immunizations and most recent booster doses

_____ DPT or DT	_____ Tuberculosis	_____ Haemophilus influenza type B
_____ MMR	_____ Pneumonia vaccination	_____ Varicella (chicken pox)
_____ Other tetanus	_____ Hepatitis B	
_____ Polio vaccine (most recent)	_____ Recent exposure to contagious disease	

This examination should be performed within 12 months of arrival at camp. Examination for some other purpose (ie: sports, school) is acceptable; please provide copy. Examination is for determining fitness to engage in activities.

CODE: (blank) = Satisfactory **X = Not Satisfactory** **0 = Not examined**

Height _____ Teeth _____
Weight _____ Heart _____
Blood pressure _____ Abdomen _____
Eyes _____ Posture (spine) _____
Glasses _____ Skin _____
Extremities _____ Lungs _____
Ears _____ Hernia _____
Nose _____ General appraisal _____
Throat _____

RECOMMENDATIONS/RESTRICTIONS WHILE AT CAMP

Special diet _____
Swimming _____
Other _____

FOR GIRLS:

Has this person menstruated? _____
If not, has she been told about menstruation? _____
If so, is her menstrual history normal? _____

HEALTH HISTORY

List any medical problems, behavior problems, operations, serious injuries or special considerations

Asthma *Treatment* _____ *Last episode* _____
Seizures *Treatment* _____ *Last episode* _____
Insect Stings _____
Diabetes *Treatment* _____
Bedwetting *Treatment* _____ *Last episode* _____
Sleepwalking _____

Drug Allergies—specify	Food Allergies—specify	Environmental Allergies—specify	Other Allergies/Insect Stings

Mental, Emotional and Social Health. ***Check "Yes" or "No" for each statement.***

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 concerns? ☐ Yes ☐ No
4. Had a significant life event that continues to affect the camper's life? ☐ Yes ☐ No

Please explain "Yes" answers on a separate sheet of paper, noting the number of the question.

The camp may contact you for additional information.

Camper's health care provider's name (please print) _____ Physical date _____
Licensed physician's name (please print) _____
Licensed physician's signature _____ License # _____
Address _____ Phone ( ) _____
Date of form completion _____ By _____
Initial if completed by nurse or physician's assistant

CAMPER'S NAME _____

PHYSICIAN 2

NOTE: The Department of Health requires that your child's physician complete the PHYSICIAN 2 form in order for your child to receive any prescription or over-the-counter medication. If a licensed health care provider does not sign this form, the camper will not be given any prescription or over-the-counter medication. Please allow your health care provider ample time to complete this form and return it to us.

HERE ARE EXAMPLES explaining why YES MUST BE CIRCLED and the form MUST BE SIGNED by the physician:

- If your child gets a bug bite and it itches, the nurse can administer Caladryl only if YES is circled and the form is signed.
- If your child has nasal congestion, the nurse can administer Sudafed only if YES is circled and the form is signed.
- If your child gets a cut, the nurse can administer an antiseptic only if YES is circled and the form is signed.

HEALTH CARE RECOMMENDATIONS: Complete with patient's current regimen for both scheduled and prn medications—use 2nd page if needed. **Please bring all medications to the camp nurse on the first day of camp.**

DRUG NAME	ROUTE Circle preferred formulation	DOSAGE	SCHEDULE AND INDICATIONS	HEALTH CARE PROVIDER ORDER	COMMENTS
PRESCRIPTION MEDICATIONS					
OTC MEDICATIONS					
Anti-acid (Tums)	PO (pills or liquid)	Per label instruction by age/weight	Q 2-4 hrs PRN-Gas, heartburn, indigestion, stomach upset	Yes No	
Antifungal cream/ spray/powder	Topical (cream, spray, powder)	Per label instructions	PRN Athletes foot, jock itch	Yes No	
Antiseptics (Alcohol, Peroxide, Bacitracin)	Topical (cream or liquid)	Per label instructions	PRN Stings/bites, cuts, scrapes, splinters, blisters	Yes No	
Benadryl/Claritin	PO (elixir, chewable tabs or pills)	Per label instruction by age/weight	Q 6 hrs PRN for allergic reaction (hives, insect bite)	Yes No	
Caladryl, Hydrocortisone	Topical (cream or gel)	Per label instructions	Q 6-8 hrs PRN Rash, skin irritation, insect bites	Yes No	
Cough drops, throat spray	PO (lozenges, spray)	Per label instruction by age/weight	PRN Cough, sore throats	Yes No	
Delsym/Robitussin/ Robitussin DM	PO (liquid)	Per label instruction by age/weight	Q 4 hrs PRN Coughs	Yes No	
Ear drops	Otic (liquid)	Per label instructions	PRN – Swimmers ear	Yes No	
Ivy Block and Tecnu	Topical (cream)	Per label instructions	Q 4 hrs PRN Contact with poison ivy	Yes No	
Lysine	PO (Chewable tabs, pills or liquid)	Per label instruction by age/weight	Q 4-6 hrs PRN pain, fever, cold symptoms, toothache, muscle aches	Yes No	
Ibuprofen/Tylenol	PO (Chewable tabs, pills or liquid)	Per label instruction by age/weight	Q 4-6 hrs PRN pain, fever, cold symptoms, toothache, muscle aches		
Orasol, Anbesol and Abreva	Topical (liquid or cream)	Per label instructions	Q 6 hrs PRN – Oral herpes, cold sores, toothache	Yes No	
Pepto-Bismol	PO (liquid or chewable tabs)	Per label instructions	Q 30 minutes to 1 hr PRN for diarrhea (no>8 doses/24 hours)	Yes No	
Sudafed/ Pseudoephedrine	PO (Chewable tabs, pills or liquid)	Per label instruction by age/weight	Q 4-6 hrs PRN – Nasal/Sinus congestion, hay fever, allergies	Yes No	
Visine	Optical (liquid)	Per label instructions	PRN- Eyestrain, eye irritation	Yes No	

A PHYSICIAN, PHYSICIANS ASSISTANT OR NURSE PRACTITIONER MUST SIGN THE STANDING ORDERS

Camper's health care provider's name (please print) _____

Licensed physician's name (please print) _____

Licensed physician's signature _____ License # _____

Address _____ Phone ( ) _____

Date of form completion _____ By _____

Initial if completed by nurse or physician's assistant