FORRESTEL RIDING
& SPORTS CAMP

office use only 1 2 3 4 5 6 7

Camper Health History and Permission to Treat

Name_____
Last *First* *Middle*

Birthdate_____ Age at camp_____ Grade in Fall_____ Gender □ Male □ Female

Home address_____
Street address *City* *State* *Zip*

Custodial parent/guardian_____

Home phone_____ Mom Cell Phone_____ Mom Work Phone_____

Dad Cell Phone_____ Dad Work Phone_____

Second Parent/guardian_____

Address_____
(if different from above) *Street address* *City* *State* *Zip*

Home phone_____ Cell Phone_____ Work Phone_____

Required If not available in an emergency, notify:

Name_____ Relationship_____

Address_____
Street address *City* *State* *Zip*

Home phone_____ Cell Phone_____ Work Phone_____

Health History

The following information must be filled in by the parent/guardian, or adult camper/staff member. The intent of this information is to provide camp health care personnel the background to provide appropriate care. Keep a copy of the completed form for you records. Any changes to this form should be provided to camp health personnel upon participant's arrival to camp. Provide complete information so that the camp can be aware of your needs.

The New York state Department of Health requires that each camper receive a physical examination within one year prior to their scheduled arrival to camp. Please include a copy of current physical from attending physician.

Month/Year of current Physical Examination Date: _____

Name of camper physician_____Phone_____

Address_____

Name of camper dentist/orthodontist_____ Phone_____

Address_____

Medication allergies (list)

_____

_____

_____

Food Alergies (list)

_____

_____

_____

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

_____

_____

_____

_____

_____

_____

_____

_____

PARENT AND PHYSICIAN'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT FORRESTEL CAMP

A. To be completed by the parent or guardian:

I request that my child _____DOB _____ receive the medication as prescribed below by our physician. The medication is to be furnished by me in the properly labeled original container from the pharmacy*.

Signature(Parent or Guardian): _____

Telephone: Home _____ Work _____ Date _____

B. To be completed by physician:

I request that my patient, as listed below, receive the following medication:

Name of Student _____ DOB _____

Diagnosis: _____

MEDICATION	DOSAGE	FREQUENCY/TIME TO BE TAKEN	ROUTE OF ADMINISTRATION

Duration of Treatment:

Possible Side Effects and Adverse Reactions (if any):

PLEASE CHECK ONE :

☐ I deem this child to be **self directed** and understand that the camp nurse, or other designated person in the case of the absence of the camp nurse, will administer the medication, including field trips.

Physician's Signature _____ Date:_____

Address: _____ Phone:_____

* Medication must be in original pharmacy labeled container with specific orders and name of medication.
* Medication and refills must be brought to camp by parent, guardian or responsible adult.

Plan reviewed with parent(s)/guardian(s):

Parent Signature:_____Date:_____

MEDICATIONS BEING TAKEN

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. **Bring enough medication to last the entire time at camp.** Keep it in the priginal package/bottle that identifies the prescribing physician (if prescribed drug), the name of the medication, the dosage, and the frequency of administration.

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:

Dietary Restrictions - the following apply to this individual.

_____ Does not eat red meat _____ Does not eat pork _____ Does not eat eggs
_____ Does not eat poultry _____ Does not eat seafood _____ Does not eat dairy products
_____ Other (describe) _____

General Questions (Explain "yes" answers below)

Has/does the participant:	YES	NO		YES	NO
1. Had any recent injury, illness or infectious disease?.....	□	□	17.Ever had problems with joints		
2. Have a chronic or recurring illness/condition?.....	□	□	(e.g., knees, ankles)?.....	□	□
3. Ever been hospitalized?.....	□	□	18. Have an orthodontic,appliance being		
4. Ever had surgery?.....	□	□	brought to camp?.....	□	□
5. Have frequent headaches?.....	□	□	19. Have any skin problems (e.g.,itching,		
6. Ever had a head injury?.....	□	□	rash,acne)?.....	□	□
7. Ever been knocked unconscious?.....	□	□	20.Have diabetes?.....	□	□
8. Wear glasses,contacts or protective eye wear?.....	□	□	21. Have asthma?.....	□	□
9. Ever had frequent ear infections?.....	□	□	22. Had mononucleosis in the past 12 mos?.....	□	□
10. Ever passed out during or after excercise?.....	□	□	23. Had problems with diarrhea/constipation?.....	□	□
11. Ever been dizzy during or after exercise?.....	□	□	24. Have problems sleepwalking?.....	□	□
12. Ever had seizures?.....	□	□	25. If female,have an abnormal menstrual		
13. Ever had chest pain during or after exercise?.....	□	□	history?.....	□	□
14. Ever had high blood pressure?.....	□	□	26. Have a history of bed-wetting?.....	□	□
15. Ever been diagnosed with a heart murmur?.....	□	□	27. Ever had an eating disorder?.....	□	□
16. Ever had back problems?.....	□	□	28. Ever had emotional difficulties for which		
			professional help was sought?.....	□	□

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

Please list any activities that your child is unable to participate in due to health concerns:

The New York state Department of Health requires current immunization dates on this health form.
IT IS REQUIRED THAT YOU HAVE A CURRENT TETANUS SHOT FOR CAMP

Which of the following has the participant had?

- □ Measles
- □ Chicken pox
- □ German measles
- □ Momps
- □ Hepatitis A
- □ Hepatitis B
- □ Hepatitis C

TB Mantoux Test
Date of last test _____
Result: □ Positive □ Negative

Please give all dates of immunization for:

Vaccine: Dates:	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 B						
Varicella(chicken pox)						

Use this space to provide any additional information about the participant's behavior and physical, emotional or mental health about which the camp should be aware. Attach sheet if more space is needed

Insurance Information

We do not provide health and accident insurance since most families already carry such coverage. Because of this, we ask that you, as a parent, recognize the element of risk and agree to assume responsibility for yourself and your children.

Please photocopy both sides of your health insurance card and inlcude a copy with your paper work.

Carrier or plan name _____ Group/Policy #_____

Important These boxes must be complete for attendance**

Parent/Guargian 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 tp porovide routine health care, adminster prescribed medications, and seek emergency medical treatment including odering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child. 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. This completed form may be photocopied for trips out of camp.

Signature of parent/guardian X _____ Date_____
Printed Name_____

CONSENT, RELEASE AND INDEMNITY AGREEMENT

I,_____ request that my son/daughter_____, be permitted to participate in Mary V.Keppler's Riding Enterprises, LTD. (FORRESTEL RIDING & SPORTS CAMP - DBA) FORRESTEL FARM RIDING & SPORTS PROGRAM and in consideration of my child being permitted to participate in said activities, I hereby release and discharge Mary V . Keppler, her agents, and Mary V. Keppler's Riding Enterprises Ltd., it's successors and assigns, from any liability of whatsoever kind for any personal injury, sickness, or medical or hospital expense occuring or resulting from or arising out of any activity or substitute activity directly or indirectly connected with M.V.K.'s Forrestel Farm Riding & Sports Camp, and I hereby assume all risk of any liability for injury or damage to the person of property of my son/ daughter, while engaged in such activities, however caused, and I further agree to indemnify and save harmless Mary V. Keppler, her agents, and Mary V. Keppler's Riding Enterprises Ltd., it's successors and assigns, from any and all claims, suits, and liability for injury to the property or to the person of my son/daughter, while engaged in activities at or connected with M.V.K.'s FORRESTEL FARM RIDING AND SPORTS CAMP.

(Parent or Guardian's Signature): X_____ Date: _____

If any camper does not adhere to the rules of M.V.K.'s FORRESTEL RIDING & SPORTS CAMP, we reserve the right to send that child home without a refund.

Signature of camper X_____

Unless otherwise stated we will assume you have granted us permission to use photographs and/or video footage of yourchild/children for camp promotional purposes.

Forrestel Farm

Riding & Sports Camp

MENINGOCOCCAL MENINGITIS VACCINATION RESPONSE FORM

New York State Public Health Law requires that a parent or guardian of campers who attend an overnight children's camp for seven (7) or more consecutive nights, complete and return the following form to the camp.

Check one box and sign below.

☐ My child_____ has had the meningococcal meningitis immunization (MCV4), for example Menactra or Menveo.

Date received: _____

☐ 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.

Signed _____ Date_____
(Parent / Guardian)

Camper's Name_____ Date of Birth:_____

Mailing Address:

_____

_____

Parent/Guardian's Email address (optional):_____

Physician Signature: _____ Date:_____

CAMPER HEALTH-CARE RECOMMENDATIONS
by LICENSED MEDICAL PERSONNEL FORM 2

Developed and reviewed by: *American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses*

Mail this form to the address below by _____ (date)

***To Parent(s)/Guardian(s): Complete this section** and give **this form (FORM 2)** and **a copy of your completed CAMPER HEALTH HISTORY FORM (FORM 1)** to your child's health-care provider for review.*

Dates will attend camp: from _____ (Month/Day/Year) to _____ (Month/Day/Year)

Camper Name: _____ (First) _____ (Middle) _____ (Last)

☐ Male ☐ Female Birth Date _____ (Month/Day/Year) Age on arrival at camp _____

Camper home address: _____

_____ (City) _____ (State) _____ (Zip Code)

Custodial parent(s)/guardian(s) phone: (_____)_____ (_____)_____

Parent(s)/guardian(s) stop here. Rest of form to be completed by medical personnel.

The following non-prescription medications are commonly stocked in camp Health Centers and are used on an as needed basis to manage illness and injury. ***Medical personnel: Cross out those items the camper should not be given.***

Acetaminophen (Tylenol)
Ibuprofen (Advil, Motrin)
Phenylephrine (Sudafed PE)
Pseudoephedrine (Sudafed)
Chlorpheneramine maleate
Guaifenesin
Dextromethorphan
Diphenhydramine (Benadryl)
Generic cough drops
Chloraseptic (Sore throat spray)
Lice shampoo or scabies cream (Nix or Elimite)
Calamine lotion
Bismuth subsalicylate (Pepto-Bismol)
Laxatives for constipation (Ex-Lax)
Hydrocortisone 1% cream
Topical antibiotic cream
Calamine lotion
Aloe

Medical Personnel: Please review the CAMPER HEALTH HISTORY FORM (FORM 1) and complete all remaining sections of this form (FORM 2). Attach additional information if needed.

Physical exam done today: ☐ Yes ☐ No (**If "No," date of last physical**: _____ (Month/Day/Year))

Forrestel requires physical exam within l12 months of start of camp

Weight: _____ lbs Height: _____ft_____in Blood Pressure_____/_____

Allergies: ☐ No Known Allergies

☐ To foods ***(list):***

☐ To medications: ***(list):***

☐ To the environment ***(insect stings, hay fever, etc.– list):***

☐ Other allergies: ***(list):***

Describe previous reactions:

Diet, Nutrition: ☐ Eats a regular diet. ☐ Has a medically prescribed meal plan or dietary restrictions:***(describe below)***

The camper is undergoing treatment at this time for the following conditions: ***(describe below)*** ☐ None.

Medication: ☐ No daily medications. ☐ Will take the following prescribed medication(s) while at camp: ***(name, dose, frequency—describe below)***

Other treatments/therapies to be continued at camp: ***(describe below)*** ☐ None needed.

Do you feel that the camper will require limitations or restrictions to activity while at camp? ☐ No ☐ Yes

If you answered "Yes" to the question above, what do you recommend? ***(describe below—attach additional information if needed)***

"I have reviewed the CAMPER HEALTH HISTORY FORM (FORM 1), and have discussed the camp program with the camper's parent(s)/guardian(s). It is my opinion that the camper is physically and emotionally fit to participate in an active camp program (except as noted above.)

Name of licensed provider (please print): _____ Signature: _____ Title: _____

Office Address _____ (Street) _____ (City) _____ (State) _____ (Zip Code)

Telephone: (_____)_____ Date: _____

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Camper Name First Middle Last

(For Camp Use) Cabin or Group _____

(For Camp Use) Session Code(s): _____

Forrestel Riding & Sports Camp
Allergy Action Plan

Campers Name:_____DOB:_____
Allergy To:_____

Asthmatic: __Y __N * Higher risk for severe reaction. Allergy confirmed by (circle) symptoms / skin test / blood test

STEP 1: TREATMENT

Symptoms:		**Give Checked Medication**
• **If a food allergen has been ingested, but *no symptoms*;**		**__ Epi Pen __Antihistamine**
• **Mouth**	**Hives, tingling, or swelling of lips, tongue, mouth**	**__ Epi Pen __Antihistamine**
• **Skin**	**Hives, itchy rash, swelling of face or extremities**	**__ Epi Pen __Antihistamine**
• **Gut**	**Nausea, abdominal cramps, vomiting, diarrhea**	**__ Epi Pen __Antihistamine**
• **Throat ***	**Tightening of throat, hoarseness, hacking cough**	**__ Epi Pen __Antihistamine**
• **Lung ***	**Shortness of breath, repetitive coughing, wheezing**	**__ Epi Pen __Antihistamine**
• **Heart ***	**Thready pulse, low blood pressure, fainting, pale, blueness**	**__ Epi Pen __Antihistamine**
• **Other ***	**_____**	**__ Epi Pen __Antihistamine**
• **If reaction is progressing**	**(several of the above areas affected), give**	**__ Epi Pen __Antihistamine**

The severity of symptoms can quickly change. ***** **Potentially life-threatening**

Dosage:

Epinephrine: inject intramuscularly (circle one) Epi Pen Epin Pen Jr. Twinject 0.3 Twinject 0.15
(reverse side for instructions)

Antihistamine: Give_____
(Medication / dose / route)

Other: Give_____
(Medication / dose / route)

Self Carry / Self Administer: __Y __N Authorization to be medicated at camp; __Y __N

STEP 2: EMERGENCY CALLS

1. **Call 911 (or rescue squad:_____). State an allergic reaction has been treated, and additional epi may be needed.**
2. **Medical Provider:_____at _____**
3. **Emergency Contacts**

Name/Relationship	**Phone Number(s)**	
a._____	**_____**	**_____**
b._____	**_____**	**_____**
c._____	**_____**	**_____**

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Parent / Guardian Signature:_____ Date:_____

Medical Provider's Signature:_____ Date:_____