Camp Herrlich
Summer Camp

101 Deacon Smith Hill Road
Patterson, NY 12563
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healthcenter@campherrlich.org
www.campherrlich.org

REQUIRED MEDICAL HISTORY

(Parent or Legal Guardian to Complete)

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

Dates Camper will attend Camp:

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/guardians 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___ Special Dietary Needs
Yes___ No___ Asthma
Yes___ No___ Contact Lenses
Yes __ No___ ADD/ADHD
Yes___ No___ Stomach or Bowel Problems
Yes___ No___ Seizure Disorder
Yes___ No___ Diabetes ____ Type 1____Type 2
Yes___ No___ Heart Trouble
Yes___ No___ Bleeding Disorder
Yes___ No___ ODD
Yes___ No___ Bonded Teeth
Yes___ No___ Depression or Anxiety
Yes___ No___ Urinary/Kidney Problems

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
Date of last tetanus shot (Month/Year):_____

Does this person take any medication (including prescription, over the counter medication, inhalers, epi-pen, etc.)?
Yes* ___ No ____ Will this medication be taken at Camp? 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!**

There are 2 parent pages to complete, please complete both pages and required signatures.

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_____

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:

_____

_____

****Parent/Guardian 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

****Parents/Guardian Signature**:_____ **Date**:_____

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 including but not limited to sutures, casts, any x-rays or CT scans requiring radiation. I also understand that I, the parent or guardian, is responsible for transport home of my camper due to illness or injury. In the event of a communicable disease outbreak, I understand this person will be excluded from camp if not fully immunized. I also understand that all medical forms must be complete and on file BEFORE my camper begins their camp session.

****Parent/Guardian Signature _____Date:_____**

Parents and Guardians, please make sure you attach a copy of your camper's immunizations and a copy of a physical from within one year of the beginning of Camp. If your camper takes medication and will be taking it at Camp, THE DOCTOR MUST COMPLETE THE "Prescription Medication" and/or "Emergency Medication" section of this form. We also ask that the doctor ***AND PARENT* sign off on the Over the Counter Medication form in case of emergency allergic reaction or for ANY as needed medicine while at Camp.**

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**
□	□	Allergies	To What:	
□	□	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		

Please attach full immunization history

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

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 DIAGNOSIS

_____

_____

_____

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.):

_____

_____

Child's Name: _____

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#_____

Standard Over the Counter Medications:

The following medications may be available in the Health Center and will be administered, as needed to manage injury and illness, at the discretion of the Health Director, with **Physician's Order** and **Parental Permission**. Package dose and schedule will be followed unless otherwise instructed in comment box.

Drug Name	Route	Indications	Comments
Ibuprofen	PO	Pain, fever, cold sx, toothache, muscle aches	
Acetaminophen	PO	Pain, fever, cold sx, toothache, muscle aches	
Robitussen	PO	Cough	
Cough Drops & Lozenges	PO	Cough, sore throat	
Allergy tab: Claritin/Zyrtec	PO	Seasonal/Environmental Allergies	
Dipenhydramine	PO	Insect bites, allergies, respiratory allergies	
Antacid	PO	Gas, heartburn, indigestion, stomach upset	
Milk of Magnesia	PO	Constipation	
Calamine, Caladryl, Hydrocortisone	Topical	Insect bites, rash, skin irritation	
Bacitracin, Neomycin, Polymycin	Topical	Cuts, scrapes	
Antifungal Cream, Spray	Topical	Athletes foot, jock itch	
Orajel, Abreva	Topical	Oral herpes, cold sores, toothache	
Visine	Topical	Eye Strain, Eye irritation	
Medicaine/Bactine/Benadryl Spray	Topical	Insect Stings	

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: _____