



The Nature Place Day Camp - 2011 Medical Form

THIS FORM IS TO BE COMPLETED AND SIGNED BY BOTH PARENTS/GUARDIANS AND PHYSICIAN.

Note: NO CAMPER WILL BE ALLOWED TO ENTER CAMP WITHOUT THIS COMPLETED FORM WHICH IS REQUIRED BY THE N.Y.S. HEALTH DEPARTMENT.

EXAM MUST BE WITHIN 12 MONTHS OF STARTING CAMP.

This Section To Be Filled Out By Parents

Camper's Last Name _____ **First Name** _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Birthdate _____

Parents's Last Name _____ **First Name** _____

Parent's Address _____

City _____ State _____ Zip _____

Parent Home Phone _____ Cell Phone _____

Business Phone _____ Email _____

Parents's Last Name _____ **First Name** _____

Parent's Address _____

City _____ State _____ Zip _____

Parent Home Phone _____ Cell Phone _____

Business Phone _____ Email _____

Emergency Contacts (If we can not reach parent, you must list three)

	Name	Address	Phone #
1			
2			

3			
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Health History

Please answer and explain yes answers below		YES	NO			YES	NO
1	Recent Injury, illness or infectious disease?			14	Skin Problems?		
2	Chronic or recurring illness/condition?			15	Kidney Disease?		
3	Ever been hospitalized?			16	Diabetes?		
4	Ever had surgery?			17	Braces/Retainer?		
5	Frequent Headaches?			18	Asthma?		
6	Head Injury?			19	Bleeding/Clotting Issues?		
7	Ever knocked unconscious?			20	Use a hearing aid?		
8	Glasses, contacts, protective eye wear?			21	Ever stung by a bee?		
9	Frequent ear Infections?			22	Emotional Difficulties?		
10	Convulsions/seizures?			23	Eating disorder?		
11	Heart Disease/heart murmur?			24	Use an EPI PEN?		
12	Fainting/dizziness?			25	Diet Restrictions?		
13	High Blood Pressure?						

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

Allergies (Animals, Food, Insects, Medication, Seasonal), please describe reaction and how handled.

Does your child use an EPI PEN? If yes, please give complete details regarding allergy and symptoms.

Does your child have any special needs – medical, emotional, learning? Our goal is to provide a complete camping experience for all of our campers. To aid us in accomplishing this goal we ask you to provide any additional information about your child which the camp should be aware.

Parental Consent

This health record is correct as far as I/we know, and the person described has my permission to engage in all camp activities except as specifically noted. I hereby give permission to the medical personnel selected by the Camp Directors, the Camp Medical Director or the Trip Leader to provide routine health care; to administer medications; to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the Camp Directors, the Camp Medical Director or the Trip Leader, to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

In addition, I give permission to give my child **over the counter medications and/or prescription medications** according to standard dose and your written doctor's order (see last page):

BENADRYL Yes ___ No ___ **IBUPROFEN** Yes ___ No ___ **TYLENOL** Yes ___ No ___ **Prescription Meds** Yes ___ No ___
 Prescription Medication (Name) _____

Signature of Parent/Guardian

Date

Signature of Parent/Guardian

Date

This Section To Be Filled In By Physician

Height	Allergies to Medication
Weight	Allergies to Insects
Blood Pressure	Allergies to Food
Hearing	Allergies to Plants
Hearing Aid	Coordination of Motor Skills
Vision	

Significant Health History, i.e. allergies, chronic or recurring condition, surgery, serious injuries, cardiac etc.

Is this child currently taking medication that will need to be administered at camp? (Indicate medication and dosage)

Does this child have any physical, emotional or mental disability that will affect participation in any camp activity?

Surgery (what/when)

IMMUNIZATION RECORD: PLEASE LIST DATES

*DPT	#1	#2	#3	#4	#5
TETANUS BOOSTER	#1	#2	#3	#4	
*POLIO	#1	#2	#3	#4	
*HIB	#1	#2	#3	#4	
*MEASLES	#1	#2**			
*MUMPS	#1				
*RUBELLA	#1				
*HEPATITIS B	#1	#2	#3		
TUBERCULIN TEST					
*Varicella (CHICKEN POX)					

**(#2 MMR required if born on or after 1/1/85)

*REQUIRED BY LAW OR MUST HAVE NOTE OF EXEMPTION FROM PHYSICIAN

SIGNATURE OF PHYSICIAN

Physician's Address:

Phone: ()

Date of Examination:

(Must be within 12 months of starting camp)

INDIVIDUALIZED ORDERS for: Name _____

DOB _____ Weight _____

Standard Over the Counter/PRN Medications (The following medications are available in the Nurse's Office and will be administered at the discretion of the RN, **if written approval is indicated by the camper's physician.**) THESE ARE THE ONLY OTC MEDICATIONS THAT THE CAMP WILL PROVIDE.

Drug Name	Dosage	Schedule and Indications	Doctor's Order	Comment
Benadryl	Per label instructions by age/weight	Q 6 hr prn for allergic reaction (hives, insect bite)	Yes _____ No _____	
Ibuprofen	Per label instructions by age/weight	Q 6 hr prn for pain or fever > _____ F	Yes _____ No _____	
Tylenol	Per label instructions by age/weight	Q 4 hr prn for pain or fever > _____ F	Yes _____ No _____	
Epi Pen			Yes _____ No _____	
Inhaler			Yes _____ No _____	
Prescription Medication			Yes _____ No _____	

Please sign and date this document

Camper's Physician's Name _____

Phone _____ License # _____

Address _____

Physician Signature _____ Date _____

These orders are valid for the 2011 Nature Place Day Camp season.

**COMPLETED FORM MUST BE RETURNED BY 5/13/11 FOR ALL CAMPERS
NO MATTER WHAT WEEK CHILD STARTS CAMP**

**The Nature Place Day Camp
285 Hungry Hollow Road
Chestnut Ridge, NY 10977
845-356-6477 - Phone**

845-356-2932 - Fax