

Please check here if camper is taking medication (including over-the-counter or nonprescription drugs) on a routine basis
PLEASE NOTE: EACH PAGE OF THIS MEDICAL FORM MUST BE SIGNED BY A PARENT OR LEGAL GUARDIAN



French Woods
Performing Arts Camp, Inc.
 P.O. Box 609 • Hancock, New York 13783
 845-887-5600 (Phone)
 845-887-5075 (Fax)



MEDICAL FORM

For office use

Year - 2012

Bunk #

Name

The information on this form is not part of the camper acceptance process, but is gathered to assist us in identifying appropriate care. This form, except for the "Health Recommendations of Licensed Medical Personnel," is to be filled in by parents/guardians of minors. **THESE FORMS SHOULD BE RETURNED NO LATER THAN MAY 1ST.**

Name _____ Birth date _____ Age at camp _____
Last First

Home address _____
Street address City State Zip

Social Security number of participant _____ Gender: Male Female

Custodial parent/guardian _____ Phone _____

Home address _____
(If different from above) Street address City State Zip

Business address _____ Phone _____
Street Address City State Zip Cell _____

Second parent or guardian or emergency contact _____

Address _____ Phone _____
Street Address City State Zip

Business address _____ Phone _____
Street Address City State Zip Cell _____

If not available in an emergency, notify:

Name _____

Relationship _____ Phone _____

Address _____
Street Address City State Zip

Insurance Information

Is the participant covered by family medical/hospital insurance? Yes No

If so, indicate carrier or plan name _____ Group # _____

Carrier address _____

Name of insured _____ Relationship to participant _____

Social Security number of policy holder or insurance ID number _____

Important - These boxes must be complete for attendance at camp

Permission to Provide Necessary Treatment or Emergency Care: I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me/or 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 the person named above. This completed form may be photocopied for trips out of camp.

Signature of parent or guardian **X** _____ Date _____

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

Signature of minor _____ Date _____

Health History (to be completed by Parent or Guardian)

Camper's Name: _____

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

Has your child had any of the following? (check all that apply and explain answers on a separate piece of paper)

- Recent Injury or Illness
- Chronic/Recurrent illnesses
- Ever had Surgery
- Ever been Hospitalized
- Frequent Headaches
- Ever had a Head Injury
- Ever been Knocked Unconscious
- Glasses, Contacts, Eye wear
- Frequent Ear Infections

- Seizures
- Heart Murmur
- Back Problems
- Joint Problems
- Skin Problems
- Diabetes
- Asthma
- Recurring Diarrhea/Constipation
- Sleepwalking
- Bed-Wetting
- Eating Disorders
- Mononucleosis (mono) in the past 12 months
- ADD/ADHD

- Recent Infectious Disease
- Traveled Outside the Country in the Past 9 Months
- If Female, Problems with Periods/Menstruation

During or after exercise, has your child ever?

- Passed out
- Been Dizzy
- Had Chest Pain

Is your child allergic to?

- No known allergies
- Penicillin
- Sulfa
- Asprin
- Hay Fever
- Animal Dander
- Dairy
- Insect Stings
- Peanut/Nuts
- Food _____
- Other _____

MEDICATIONS BEING TAKEN: Please list ALL medications (including prescription nose sprays, eye/ear ointments, inhalers, creams and over-the-counter or nonprescription drugs) taken daily. All medication dispensed by our nurses to your child must be accompanied by an original prescription or doctor's order. All pill medications taken daily must be individually packaged by dose by CampMeds or your local pharmacy. Each dose must be separately packaged, sealed and labeled with your child's name, prescribing physician's name, name of medicine, dosage, date and time to be given. All other liquid medication, inhalers, etc. must be kept in the original packaging/bottle that states the prescribing physician, name of the medication, dosage and the frequency of administration. Please communicate directly with CampMeds or FWF Wellness Center Coordinator.

This person takes NO medications on a routine basis.

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 _____

Med #4 _____ Dosage _____ Specific times taken each day _____
Reason for taking _____

Med #5 _____ Dosage _____ Specific times taken each day _____
Reason for taking _____

Med #6 _____ 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: _____

Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary)

Emotional, or mental health about which the camp should be aware.

Name of family physician _____ Phone _____

Address _____

Name of family dentist/orthodontist _____ Phone _____

Parent/Guardian Authorizations: This health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted.

Signed **X** _____ Printed _____ Date _____

MENINGOCOCCAL MENINGITIS VACCINATION RESPONSE FORM

Dear Parents:

I am writing to inform you about meningococcal disease, a potentially fatal bacterial infection commonly referred to as meningitis, and a new law in New York State. On July 22, 2003 the New York State Public Health Law (NYS PHL) was amended to include §2167 requiring overnight children's camps to distribute information about meningococcal disease and vaccination to the parents or guardians of all campers who attend camp for 7 or more nights. This law became effective on August 15, 2003.

French Woods is required to maintain a record of the following for each camper:

- A response to receipt of meningococcal meningitis disease and vaccine information signed by the camper's parent or guardian; AND
- Information on the availability and cost of meningococcal meningitis vaccine (Menomune™); AND EITHER
- A record of meningococcal meningitis immunization within the past 10 years; OR
- An acknowledgement of meningococcal meningitis disease risks and refusal of meningococcal meningitis immunization signed by the camper's parent or guardian.

Meningitis is rare. However, when it strikes, its flu-like symptoms make diagnosis difficult. If not treated early, meningitis can lead to swelling of the fluid surrounding the brain and spinal column as well as severe and permanent disabilities, such as hearing loss, brain damage, seizures, limb amputation and even death.

Cases of meningitis among teens and young adults 15 to 24 years of age have more than doubled since 1991. The disease strikes about 3,000 Americans each year and claim about 300 lives.

A vaccine is available that protects against four types of the bacteria that cause meningitis in the United States – types A, C, Y and W-135. These types account for nearly two-thirds of meningitis cases among teens and young adults. Information about the availability and cost of the vaccine can be obtained from your health care provider and by visiting the manufacturer's website at www.meningitisvaccine.com

I encourage you to carefully review the enclosed materials. **Please complete the Meningococcal Vaccination Response Form.**

To Learn more about meningitis and the vaccine, please feel free to contact the French Woods office, 1-800-634-1703 and/or consult your child's physician. You can also find information about the disease at the New York State Department of Health website: www.health.state.ny.us, and the website of the Center for Disease Control and Prevention (CDC): www.cdc.gov/ncidod/dbmd/diseaseinfo

Sincerely,



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 for seven (7) or more nights.

Check one box and Sign Below

- My Child has had the meningococcal meningitis immunization (Menomune™) within the past 10 years.

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: **X** _____
(Parent/Guardian)

Date: _____

Pages 4 and 5 to Be Filled Out and Signed By Physician

Camper's Name: _____

New York State Law requires this section to be filled out by a physician in order for our nurses to dispense over-the-counter non-prescription medication to your child when needed.

Standing Orders for Standard Over the Counter / PRN Medication
(meds available in the infirmary to be administered at the discretion of an RN)

DRUGS	ROUTE	DOSAGE	SCHEDULE	PROVIDER ORDER	COMMENTS
Tylenol	(Chewable tabs elixer or tabs)	Per label Instructions by age/weight	Q 4 hr prn for pain or fever> _____	Yes/ No	
Ibuprofen	(Chewable tabs elixer or tabs)	Per label Instructions by age/weight	Q 4 hr prn for pain or fever> _____	Yes/ No	
Robitussin	(Chewable tabs elixer or tabs)	Per label Instructions by age/weight	Q 4 hr prn for cough	Yes/ No	
Pepto-Bismol	(Chewable tabs elixer or tabs)	Per label Instructions by age/weight	Q 2-4 hr prn for diarrhea (no>8 doses/24hr)	Yes/ No	
Children's Mylanta	(Chewable tabs elixer or tabs)	Per label Instructions by age/weight	BID-TID prn for upset stomach	Yes/ No	
Dramamine	(Chewable tabs elixer or tabs)	Per label Instructions by age/weight	Q 6-8 hr for motion sickness	Yes/ No	
Dimetapp	(Chewable tabs elixer or tabs)	Per label Instructions by age/weight	Q 6-8 hrs for nasal congestion/ drainage	Yes/ No	
Phenylephrine	(Chewable tabs elixer or tabs)	Per label Instructions by age/weight	Q 6-8 hrs for nasal congestion/ drainage	Yes/ No	
Benadryl	(Chewable tabs elixer or tabs)	Per label Instructions by age/weight	Q 6 prn for allergic reaction (hives, insectbites)	Yes/ No	
Hydrocortisone	(Cream)	Per label Instructions by age/weight	Q prn for rash	Yes/ No	
Triple Antibiotic	(Ointment)	Per label Instructions by age/weight	Q prn for minor bacterial infections	Yes/ No	
Immodiumm	(Chewable tabs elixer or tabs)	Per label Instructions by age/weight	Q 2-4 hr prn for diarrhea (no>8 doses/24hr)	Yes/ No	

I give the camp medical staff permission to administer the non-prescription medications listed above. I have circled "No" for those the camper should not be given.

Parent's Signature: _____ **Date:** _____

Immunization History: Provide the month and year for each immunization. Starred (*) immunizations must be current. **A copy of the immunization record signed by your physician will be accepted.**

Immunization	Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most Recent Dose Month/Year
Diphtheria, tetanus, pertussis* (DTap) or (TdaP)						
Tetanus booster* (dT) or (TdaP)						
Mumps, measles, rubella* (MMR)						
Polio * (IPV)						
Haemophilus influenza type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox)	<input type="checkbox"/> Had chicken pox Date: _____					
Meningococcal meningitis (MCV4)						
BCG						

Tuberculosis (TB) Mantoux Test Date: _____ Negative Positive

Name of Physician: _____ **Phone** _____

Address _____

Pages 4 and 5 To Be Filled Out and Signed By Physician

Health Care Recommendations by Licensed Medical Personnel

Camper's Name: _____

I have examined the above camp participant. Date of last examination _____

BP _____ Weight _____ Height _____

In my opinion, the above applicant is is not able to participate in an active camp program.

The applicant is under the care of a physician for the following conditions:

Current treatment at the time of this report includes:

Standing Orders for Recommendations and Restrictions at Camp

Treatment to be continued at camp:

Medications to be administered at camp (name, dosage, frequency):

Any medically-prescribed meal plan or dietary restrictions:

Known allergies:

Description of any limitation or restriction on camp activities:

Additional information for health care staff at the camp:

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.

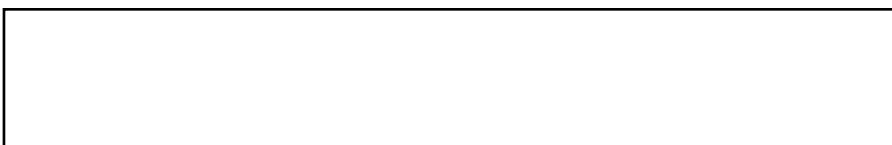
I have examined the patient herein described and have reviewed the health history. It is my opinion that this child is physically able to engage in the regular camp activities, except as noted. Please be aware that this constitutes a doctor's order. Children will not receive medication other than that which is listed on previous pages or above.

Name of Child (Please Print) _____

Physician's Signature _____ **Physician's Name**(Print) _____ **Date** _____

Physician's Phone # _____ **Physician's Address** _____

Physician's Stamp here:



Parent/Guardian Authorizations: This health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted.

Signed X _____ **Printed** _____ **Date** _____

Camper's Name: _____

INSURANCE INFORMATION FORM

PLEASE ATTACH COPIES OF THE FRONT AND BACK OF YOUR MAJOR MEDICAL INSURANCE/PRESCRIPTION DRUG/DENTAL CARD(S).

Participant's Date of Birth _____ Social Security Number _____

Family Name _____ Telephone Number _____

MEDICAL INSURANCE INFORMATION:

Is the participant covered by family medical/hospital insurance? Yes No

Carrier or Plan Name _____ Carrier Phone # _____

Carrier Address _____ City _____

State _____ Zip _____ Group # _____ Amount of Co-Pay _____

Name of Insured _____ Relation to Participant _____

Social Security Number of Policy holder or the Member ID Number _____

PRESCRIPTION INSURANCE INFORMATION:

Is the participant covered by family prescription insurance? Yes No

Carrier or Plan Name _____ Carrier Phone # _____

Carrier Address _____ City _____

State _____ Zip _____ Group # _____ Amount of Co-Pay _____

Name of Insured _____ Relation to Participant _____

Social Security Number of Policy holder or the Member ID Number _____

Medication Allergies _____

DENTAL INSURANCE INFORMATION:

Is the participant covered by family dental insurance? Yes No

Carrier or Plan Name _____ Carrier Phone # _____

Carrier Address _____ City _____

State _____ Zip _____ Group # _____ Amount of Co-Pay _____

Name of Insured _____ Relation to Participant _____

Social Security Number of Policy holder or the Member ID Number _____

We will call to let you know if we need to order prescription medications for your child. Please provide a credit card number we can use to charge such expenses.

Card # _____ Expiration: _____

Parent's signature _____

GENERAL PERMISSION STATEMENT I/we give permission for my/our child to participate in all of French Woods Festival of the Performing Arts programs and activities and understand that accidents and injuries may occur in the natural course of participation in activities. I/we understand that there are at times trips out of camp and give permission for French Woods Performing Arts Camp, Inc. to take my/our child out of camp to participate in these activities. I/we understand that the camp will provide medical service in camp but it is necessary for my/our child to receive medical treatment outside of camp the health care provider will bill this to my/our insurance carrier.

Parent's signature _____ **Date** _____