



# French Woods

## Performing Arts Camp, Inc.

P.O. Box 609  
 Hancock, New York 13783  
 845-887-5600 efax 845-503-2179

### MEDICAL FORM



For office use

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.

Year - 20

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-please include a photocopy of Health Insurance card & prescription medication card to be used in the event that medical treatment or medication is required.**

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 \_\_\_\_\_

     Please check here if camper is taking medication (including over-the-counter or nonprescription drugs) routinely

**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 \_\_\_\_\_

Name

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

Signature of minor \_\_\_\_\_ Date \_\_\_\_\_

# Health History

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 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 participant'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)
- Recent Injury or Illness
  - Chronic/Reoccurring condition
  - Ever had surgery
  - ever been hospitalized
  - Frequent Headaches
  - Ever have a head injury
  - Ever been knocked out
  - Glasses, Contacts, Eye wear
  - Frequent Ear Infections
  - Heart Murmur
  - Seizures
  - Back Problems
  - Joint Problems
  - problems with menstruation
  - Skin Problems
  - Diabetes
  - Asthma
  - Recurring Diarrhea/Constipation
  - Sleepwalking
  - Bed-Wetting
  - Eating Disorders
  - Mononucleosis past year
  - ADD / ADHD

- During or after exercise, has your child ever:
- Passed out
  - Been Dizzy
  - Had Chest Pain

- Is your child allergic to:
- Penicillin
  - Sulfa
  - Aspirin
  - Hay Fever
  - Animal Dander
  - Dairy
  - Insect Stings
  - Peanut / Nut
  - Insect Stings
  - Food \_\_\_\_\_
  - Other \_\_\_\_\_

Please explain \_\_\_\_\_

Describe reaction \_\_\_\_\_

Please explain \_\_\_\_\_

**MEDICATIONS BEING TAKEN:** Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. All medication in pill form taken routinely must be individually packaged by Camp Meds, Inc., or your local pharmacy. Each individually sealed packet must be labeled by the pharmacy with your child's name, medicine, dosage, date and time to be given, and prescribing physician. All other liquid medication, inhalers, etc. must be kept in the original packaging/bottle that identifies the prescribing physician, the name of the medication, the dosage, and the frequency of administration. ***Please check physician's page for dosage and frequency.***

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 _____		

Attach additional pages for more medications.  
Identify any medications taken during the school year that participant does/may not take during the summer: \_\_\_\_\_

## RESTRICTIONS

The following restrictions apply to this individual.

### Dietary

- 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) \_\_\_\_\_

**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 \_\_\_\_\_

Address \_\_\_\_\_

**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 Parent

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](http://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](http://www.health.state.ny.us), and the website of the Center for Disease Control and Prevention (CDC): [www.cdc.gov/ncidod/dbmd/diseaseinfo](http://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: \_\_\_\_\_

Campers Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

## INSURANCE INFORMATION

**\*PLEASE ATTACH COPIES OF YOUR PRESCRIPTION AND INSURANCE CARDS, FRONT AND BACK TO THIS FORM.**

In the event that your camper needs to have medication that is not stocked in our camp infirmary the following information is mandatory for you to be able to use any drug plan:

All pertinent information will be given to the pharmacist.

CAMPER'S NAME \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ SOCIAL SECURITY NUMBER \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

FAMILY NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

\_\_\_\_\_

TELEPHONE NUMBER \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

AMOUNT OF COPAY (DEDUCTIBLE) \_\_\_\_\_

MEDICATION ALLERGIES \_\_\_\_\_

FAMILY MEDICAL/HOSPITAL INSURANCE NAME \_\_\_\_\_

CERTIFICATION NUMBER \_\_\_\_\_

GROUP NUMBER \_\_\_\_\_

CARRIER ADDRESS \_\_\_\_\_

\_\_\_\_\_

CARRIER PHONE NUMBER \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

NAME OF INSURED \_\_\_\_\_

for prescription cards:

Rx Group # \_\_\_\_\_ Rx Bin # \_\_\_\_\_

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

Type of card \_\_\_\_\_ Card # \_\_\_\_\_ Expiration: \_\_\_\_\_

Signature: **X** \_\_\_\_\_

**To Be Filled Out 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.*

**Standard Over the Counter / PRN Medication**

*(meds available in the infirmary/ first aid to be administered at the discretion of an RN)*

DRUGS	ROUTE	DOSAGE	SCHEDULE	PROVIDER ORDER	COMMENTS
Tylenol	PO (Chewable tabs elixer or tabs)	Per label Instructions by age/weight	Q 4 hr prn for pain or fever> _____	Yes/ No	
Ibuprofen	PO (Chewable tabs elixer or tabs)	Per label Instructions by age/weight	Q 4 hr prn for pain or fever> _____	Yes/ No	
Robitussin	PO (Chewable tabs elixer or tabs)	Per label Instructions by age/weight	Q 4 hr prn for cough	Yes/ No	
Pepto-Bismol/Kaopectate	PO (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	PO (Chewable tabs elixer or tabs)	Per label Instructions by age/weight	BID-TID prn for upset stomach	Yes/ No	
Dramamine	PO (Chewable tabs elixer or tabs)	Per label Instructions by age/weight	Q 6-8 hr for motion sickness	Yes/ No	
Dimetapp	PO (Chewable tabs elixer or tabs)	Per label Instructions by age/weight	Q 6-8 hrs for nasal congestion/ drainage	Yes/ No	
Phenylephrine	PO (Chewable tabs elixer or tabs)	Per label Instructions by age/weight	Q 6-8 hrs for nasal congestion/ drainage	Yes/ No	
Benadryl	PO (Chewable tabs elixer or tabs)	Per label Instructions by age/weight	Q 6 prn for allergic reaction (hives, insectbites)	Yes/ No	
Hydrocortisone	PO (Cream)	Per label Instructions by age/weight	Q prn for rash	Yes/ No	
Triple Antibiotic	PO (Ointment)	Per label Instructions by age/weight	Q prn for minor bacterial infections	Yes/ No	
Immodium	PO (Chewable tabs elixer or tabs)	Per label Instructions by age/weight	Q 2-4 hr prn for diarrhea (no>8 doses/24hr)	Yes/ No	
acetaminophen	PO (Chewable tabs elixer or tabs)	Per label Instructions by age/weight	Q 4 hr prn for pain or fever> _____	Yes/ No	
claritin/clarinex	PO (Chewable tabs elixer or tabs)	Per label Instructions by age/weight	Q 6 prn for allergic reaction (hives, insectbites)	Yes/ No	
lice shampoo or cream (Nix/Eliminate)	PO (liquid)	Per label Instructions by age/weight	as needed	Yes/ No	
Calamine Lotion	PO (liquid or cream)	Per label Instructions by age/weight	as needed	Yes/No	
Cough Drops	PO (Chewable tabs)	Per label Instructions by age/weight	as needed	Yes/No	

***PLEASE MAKE SURE THE ABOVE IS FILLED OUT IN ITS ENTIRETY AND SIGNED BELOW. THIS IS EXTREMELY IMPORTANT!***

**Immunization**

Which of the following has the participant had?

- Measles
- Chicken Pox
- German measles
- Mumps
- Hepatitis

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)	_____	_____	_____	_____	_____	_____
BCG	_____	_____	_____	_____	_____	_____

TB Mantoux Test  
Date of last test \_\_\_\_\_  
Result:  Positive  Negative

Name of family physician \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Physicians Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent's Signature: **X** \_\_\_\_\_ Date \_\_\_\_\_

## To Be Filled Out 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

### Recommendations and Restrictions at Camp

Treatment to be continued at camp \_\_\_\_\_

Medications to be administered at camp: ***Please be clear and concise-use additional pages if needed.***

<input type="checkbox"/> This person takes NO medications on a routine basis while at camp.					
<input type="checkbox"/> This person will take the following daily medication(s) while attending camp:					
name of medication	date started	reason for taking it	when it is given	amt of dose given	How it is given
			<input type="checkbox"/> breakfast <input type="checkbox"/> lunch <input type="checkbox"/> dinner <input type="checkbox"/> bedtime <input type="checkbox"/> other: _____		
			<input type="checkbox"/> breakfast <input type="checkbox"/> lunch <input type="checkbox"/> dinner <input type="checkbox"/> bedtime <input type="checkbox"/> other: _____		
			<input type="checkbox"/> breakfast <input type="checkbox"/> lunch <input type="checkbox"/> dinner <input type="checkbox"/> bedtime <input type="checkbox"/> other: _____		

Attach additional pages for more medications.

Identify any medications taken during the school year that participant does/may not take during the summer: \_\_\_\_\_

Any medically-prescribed meal plan or dietary restrictions

Known allergies & previous symptoms

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. (add more pages if needed)**

*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 above.*

Name of Child (Please Print) \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Physician's Name(Print) \_\_\_\_\_ Date \_\_\_\_\_

Physician's Phone # \_\_\_\_\_ Parent's Signature **X** \_\_\_\_\_

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 \_\_\_\_\_