



French Woods

Performing Arts Camp, Inc.

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



MEDICAL FORM

For office use

Year - 2010

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.

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

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) | <input type="checkbox"/> Back Problems | During or after exercise, has your child ever: | Is your child allergic to: |
| <input type="checkbox"/> Recent Injury or Illness | <input type="checkbox"/> Joint Problems | <input type="checkbox"/> Passed out | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Chronic or Reoccurring condition | <input type="checkbox"/> Skin Problems | <input type="checkbox"/> Been Dizzy | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Ever had surgery | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Had Chest Pain | <input type="checkbox"/> Asprin |
| <input type="checkbox"/> ever been hospitalized | <input type="checkbox"/> Asthma | | <input type="checkbox"/> Hay Fever |
| <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Recurring Diarrhea/Constipation | | <input type="checkbox"/> Animal Dander |
| <input type="checkbox"/> Ever have a head injury | <input type="checkbox"/> Sleepwalking | | <input type="checkbox"/> Dairy |
| <input type="checkbox"/> Ever been knocked unconscious | <input type="checkbox"/> Bed-Wetting | | <input type="checkbox"/> Insect Stings |
| <input type="checkbox"/> Glasses, Contacts, Eye wear | <input type="checkbox"/> Eating Disorders | | <input type="checkbox"/> Peanut / Nut |
| <input type="checkbox"/> Frequent Ear Infections | <input type="checkbox"/> Mononucleosis in the past 12 months | | <input type="checkbox"/> Insect Stings |
| <input type="checkbox"/> Seizures | | | <input type="checkbox"/> Food _____ |
| <input type="checkbox"/> Heart Murmur | | | <input type="checkbox"/> Other _____ |

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 White's Pharmacy, Camp Meds, 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.

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

- | | | |
|--|---|--|
| <input type="checkbox"/> Does not eat red meat | <input type="checkbox"/> Does not eat pork | <input type="checkbox"/> Does not eat eggs |
| <input type="checkbox"/> Does not eat poultry | <input type="checkbox"/> Does not eat seafood | <input type="checkbox"/> Does not eat dairy products |
| <input type="checkbox"/> 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

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: _____

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 _____

If we need to order perscription 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:

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	(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	
Immodium	(Chewable tabs elixer or tabs)	Per label Instructions by age/weight	Q 2-4 hr prn for diarrhea (no>8 doses/24hr)	Yes/ No	
	Please make sure to check YES/NO		Please make sure to check Yes/No		

Immunization

Please give all dates of immunization for:

Which of the following has the participant had?

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

Vaccine:Dates:

DTP
 TD (tetanus/diphtheria)
 Tetanus
 Polio
 MMR

Mo/Yr Mo/Yr Mo/Yr Mo/Yr Mo/Yr Mo/Yr

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 _____

Name of family dentist/orthodontist _____ Phone _____

Address _____

Parent's Signature: _____ **Sign Here! 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 (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 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** _____