

BLUE RILL DAY CAMP

444 SADDLE RIVER ROAD, AIRMONT, NY 10952
phone (845) 352-3521 fax (845) 352-0168

CAMPER NAME _____

DATE OF BIRTH _____

2010 CAMPER MEDICAL FORM – PARENT SECTION

THIS MEDICAL FORM MUST BE COMPLETED AND SIGNED BY BOTH PARENT/GUARDIAN AND PHYSICIAN. The information on this form is gathered to assist us in identifying appropriate care. Any changes to this form should be provided to camp health personnel upon the camper's arrival in camp. Provide complete information so that the camp can be aware of the camper's needs. It is imperative that camper information, emergency contacts and business information be complete and up to date each year.

Camper's Last Name _____ First Name _____ Middle _____

Home Street Address _____

City _____ State _____ Zip _____

Home Phone _____ Birth date _____ Age at camp _____

Custodial Parent(s)/Guardian(s): _____

Home Street Address (if different from above) _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone #1 _____ Cell Phone #2 _____

Business Name and Address _____

Business Phone _____ Email _____

Second Custodial Parent(s)/Guardian(s): _____

Home Street Address (if different from above) _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone #1 _____ Cell Phone #2 _____

Business Name and Address _____

Business Phone _____ Email _____

PERSONS TO BE CONTACTED IN AN EMERGENCY (minimum of three local contacts are required)

| | Name | Home Phone | Cell Phone # | Relationship |
|---|------|------------|--------------|--------------|
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |
| 4 | | | | |

Permission to Provide Necessary Treatment or Emergency Care:

I hereby give permission to the medical personnel selected by Blue Rill Day Camp 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 transportation. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by Blue Rill Day Camp to render whatever treatment he/she deems necessary, secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for out of camp trips.

I hereby give permission to give my child over the counter medications according to standard dose and your written doctor's order (see page 4):

TYLENOL Yes () No () IBUPROFEN Yes () No () BENADRYL Yes () No () OTHER () _____

PARENT / GUARDIAN SIGNATURE _____ *MUST BE SIGNED

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2010 CAMPER MEDICAL - PARENT SECTION (continued)

GENERAL QUESTIONS: (Explain "yes" answers below)

Has/does the camper:

- | | YES | NO | | YES | NO |
|--|-----|-----|--|-----|-----|
| 1. Had any recent injury, illness or infectious disease? ... | () | () | 12. Ever had seizures? | () | () |
| 2. Have a chronic or recurring illness/condition? | () | () | 13. Ever have chest pain during or after exercise? | () | () |
| 3. Ever been hospitalized? | () | () | 14. Ever had high blood pressure? | () | () |
| 4. Ever had surgery? | () | () | 15. Ever been diagnosed with a heart murmur?.. | () | () |
| 5. Have frequent headaches? | () | () | 16. Ever had back problems? | () | () |
| 6. Ever had a head injury? | () | () | 17. Ever had problems with joints (e.g., knees, ankles)? | () | () |
| 7. Ever been knocked unconscious? | () | () | 18. Have an orthodontic appliance at camp? | () | () |
| 8. Wear glasses, contacts or protective eye wear? | () | () | 19. Have any skin problems? | () | () |
| 9. Ever had frequent ear infections? | () | () | 20. Have diabetes? | () | () |
| 10. Ever been dizzy during or after exercise? | () | () | 21. Ever have asthma? | () | () |
| 11. Ever passed out during or after exercise? | () | () | 22. Ever had an eating disorder? | () | () |

Please explain any "yes" answers, noting the number of the questions:

1. Please list any allergies (food, insects, seasonal/environmental, animals, asthma, medicine); describe reaction and management:

2. Does your child need an EPI-Pen? Yes () No () If yes, describe type of allergic reaction, including signs and symptoms of distress:

3. Please describe any dietary restrictions:

4. Does your child have any special needs – medical, emotional, learning? Please provide as much detail as possible; feel free to attach additional paper if necessary:

5. Please indicate (or call us at 845-352-3521) any situations inside or outside of camp that may affect your child's behavior or attitude:

We appreciate the trust you place in us when you enroll your child at Blue Rill Day Camp. The information you provide as part of the enrollment process will be held in the strictest confidence. We do not share information with other organizations or camp personnel except where necessary to carry out our responsibilities as your representative in caring for your child. We never release information about your child to other campers or camp families without your consent.

We look forward to providing your child with a wonderful camp experience. We feel that Blue Rill is a place where children can have a fun summer, make new friends, have new experiences while developing many important skills. For the general welfare of all campers, Blue Rill reserves the unrestricted right to dismiss any camper whose conduct, in the opinion of the Directors and Administrators, is detrimental to the best interests of the Camp and our goals.

PARENT / GUARDIAN SIGNATURE _____

DATE _____

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2010 CAMPER MEDICAL FORM – PHYSICIAN’S SECTION

(PAGES 3, 4 & 5 TO BE COMPLETED BY PHYSICIAN)

HEIGHT _____ WEIGHT _____ VISION _____ HEARING _____ BLOOD PRESSURE _____ URINALYSIS _____

ANY DEFECT IN: HEART _____ LUNGS _____ TEETH _____ ABDOMEN _____ SPINE _____ NOSE & THROAT _____
EXTREMITIES _____ NERVOUS SYSTEM _____

SIGNIFICANT HEALTH HISTORY (ALLERGIES, ASTHMA, SEIZURES, CARDIAC, CHRONIC OR RECURRING CONDITIONS): _____

ANY HISTORY OF DIABETES? _____

ANY HISTORY OF CHICKEN POX? _____

ANY HISTORY OF EPILEPSY, CONVULSIONS, FAINTING? _____

ANY HISTORY OF OPERATIONS OR SERIOUS INJURIES? _____

THE APPLICANT IS UNDER THE CARE OF A PHYSICIAN FOR THE FOLLOWING CONDITIONS:

ANY MEDICALLY PRESCRIBED MEAL PLAN OR DIETARY RESTRICTIONS? _____

ANY ALLERGIES? (*Food, drugs, insects, seasonal/environmental, animal dander, etc.*)

List all known.

Describe reaction and management of reaction.

| | |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

HAS THIS CAMPER EVER BEEN STUNG BY A BEE, WASP OR INSECT BEFORE? Yes _____ No _____ *If so, please indicate the degree of reaction and special orders for immediate treatment. Common antihistamines are kept at camp and are given by our RN only with a doctor's order. Include written doctor's order here:*

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MEDICATION AUTHORIZATION FORM – PHYSICIAN’S SECTION (continued)

No medication may be administered without proper authorization from the physician. This Medical Authorization form **MUST BE COMPLETED** in order for the camp nurses to dispense over-the-counter, non-prescription medications and/or prescription medications to the camper, as per the New York State Health Department.

STANDARD OVER-THE-COUNTER/PRN MEDICATIONS:

| DRUG | ROUTE | DOSAGE | SCHEDULE | DOCTOR'S ORDER | COMMENTS |
|-----------|--|--|---|----------------|----------|
| TYLENOL | PO (chewable tabs, elixir or tabs) | Per label instructions by age/weight | Q 4 hr prn for pain or fever > _____ | YES () NO () | |
| IBUPROFEN | PO (chewable tabs, elixir or tabs) | Per label instructions by age/weight | Q 6 hr prn for pain or fever > _____ | YES () NO () | |
| BENADRYL | PO (chewable tabs, elixir or tabs) | Per label instructions by age/weight | Q 6 hr prn for allergic reaction | YES () NO () | |
| OTHER | | | | | |

EPI PEN:

Does this camper require an EPI-PEN? Yes _____ No _____

Condition: _____

INHALER:

Does this camper require an INHALER: Yes _____ No _____

Condition: _____

OTHER MEDICATIONS TAKEN AT CAMP: Yes _____ No _____

Medication: _____ Condition: _____

OTHER MEDICATIONS TAKEN AT HOME: Yes _____ No _____

Medication: _____ Condition: _____

Physician's Signature (MUST BE SIGNED) _____ Date: _____

Physician's Address _____

Physician's Telephone _____

2010 CAMPER MEDICAL FORM – PHYSICIAN’S SECTION

(continued)

IMMUNIZATIONS: (PLEASE LIST ALL DATES OR ATTACH IMMUNIZATION RECORD)

DPT _____ TD (tetanus/diphtheria) _____

TETANUS _____ POLIO _____

MMR _____ MEASLES _____ MUMPS _____ RUBELLA _____ VARICELLA _____

HEMOPHILUS INFLUENZA B _____ HEPATITIS B _____ BCG _____

TB MANTOUX TEST, DATE OF LAST TEST _____ RESULT [] POSITIVE [] NEGATIVE OTHER _____ OTHER _____ OTHER _____

IS THIS CHILD PERMITTED TO PARTICIPATE IN ALL FORMS OF PHYSICAL COMPETITION? _____

If not why? _____ Description of limitations _____

PLEASE PROVIDE ANY ADDITIONAL INFORMATION REGARDING THE PARTICIPANT’S PHYSICAL, EMOTIONAL, OR MENTAL HEALTH ABOUT WHICH THE CAMP SHOULD BE AWARE:

Date: _____

Physician’s Signature (MUST BE SIGNED) _____

Physician’s Address _____

Physician’s Telephone _____

IMPORTANT INFORMATION REGARDING THE PHYSICIAN'S SECTION

1. Please note that the Physician Section of the Camper Medical form can be found on pages 3, 4 & 5 and must be completed and returned to Blue Rill along with the Parent Section (pages 1 & 2) of the Camper Medical form.
2. A separate page is provided for over-the-counter and prescription medication authorization. As per New York State Health Department regulations, this form must be completed by your physician in order for our nurses to administer any medication to a camper.
3. As per Blue Rill policy, ALL medications must be clearly labeled with the camper's name and group and stored in the nurse's office. At no time is a camper allowed to take medication without the supervision of our nurses, and no camper is allowed to keep any medication in their cubby, bag, etc.

Please remember that in order for your child to attend camp, we must have a completed medical form (both parent and physician sections) on file. Feel free to call us if you have any questions or concerns. We appreciate your time and effort to complete and return these forms promptly!

Thank you!