CABIN: EXAM DATE: CAMP WEEK: NAME:

# Camp Judah Health Form

Camp Located at: 2970 Kohler Rd.
Varysburg, NY 14167
(585)535-7832

This form MUST be accurately completed by all campers or camp staff members and submitted with a registration form. **Part One** should be filled out by the camper's parents, **Part Two** must be filled out by your personal care physician, physician's assistant or certified nurse practitioner. Camp Hickory Hill is located on a hillside and will be physically challenging if your child's mobility is limited or health is otherwise impaired. Please be certain your child is in good health and up to the physical demands upon arrival at camp. We will be unable to safely accommodate some types of medical conditions. Please contact the camp director if you have questions regarding this health form.

## PART ONE

Please be advised that we are subject to New York State laws and require the EXACT information requested. Failure to document this information will result in delay of registration of your camper.

**Name**________________________________________ **Gender**____________**Date of Birth**____________________
**Address**_______________________________________**City**__________________**State**_______**Zip**____________

PERSON TO CONTACT IN CASE OF EMERGENCY:
Name____________________________Relationship to camper____________________Phone _________________

**Health Insurance Information**:
Carrier_______________________________________________Type__________________________________
Policy # ___________________________________________ Phone # ( )_________________________
In Whose Name? ____________________________________________________________________________

**IMMUNIZATIONS** - Please attach a copy of immunizations provided by the camper's medical care provider. If no immunizations have been given, we must have documentation attached.

Please share any further comments regarding your child's social, emotional, and/or psychological well-being that would be important for the staff to be aware of (this information will only be shared with the pastors, directors and your child's specific counselor for the safety and well-being of the campers_____________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________

Parent's Authorization (must be signed): This health form is correct so far as I know, and the person herein described has permission to engage in all camp activities, except as noted on this form. In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for my child as named above. I also authorize the camp nurse to administer treatment as per standing order protocol and to administer any medications prescribed by his/her physician as listed on this form.

______________________________________________________________________________________________
**Parent/Guardian Signature** **Relationship** **Date**

## *IMPORTANT! PLEASE READ:

Please submit **Part Two** of this health form to your child's pediatrician for their review and signature. Typical school health assessment or sports forms are not acceptable, as they do not authorize general medical care for your child in the event it is required. Please list ALL medications (including over the counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. **Keep it in the original and current packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.** Attach additional pages for more medications.

# Camp Judah Health Form

Camp Located at: 2970 Kohler Rd.
Varysburg, NY 14167
(585)535-7832

## PART TWO

## Dear Health Care Provider,

Your patient: ____________________________ DOB: _____________ is applying to attend a week of summer camp. There will be a Camp Health Director at camp during the week to provide for any health care needs of all campers. In addition to the use of basic medical supplies to provide for general health care, the Camp Health Director is able to consult with an area M.D., P.A. or C.N.P. should the need arise. Your office and the camper's parents would also be contacted should the situation warrant. There is a local hospital approximately 15 miles away where emergency services are available at all times. Please review the following general prn orders, deleting (by crossing out and initialing) or adding any additional OTC or prescription medications. Your signature at the bottom will authorize the Camp Health Director to administer treatment should your patient require general health care during his/her week at camp. (The Camp Health Director meets all certification standards according to the New York State Sanitary Code for Overnight Camps – He or she is typically an RN, but may be an EMT, LPN, MD, PA or CNP.)

**Orders for Camp Nursing Care**

**Seasonal Allergy Symptoms**: Benadryl, Loratadine, Cetirizine, or Fexofenadine per dosing instruction.
________________________________________________________________________________

**Mild Pain**: Tylenol or Ibuprofen per dosing instruction. _______________________________________

**Bee Sting WITH anaphylactic reaction (or ANY ANAPHYLACTIC REACTION):** Give epinephrine (bee sting kit) and call 911 immediately. ________________________________________________
**Contact Dermatitis/Skin Allergies**: Apply hydrocortisone cream per dosing instruction.

**Stomach upset**: Assess for dehydration, give clear liquids. Tums may be given for acid indigestion.

**Fungal-type Skin infections**: Apply Clotrimazole cream per dosing instruction.

**Persistent Cough**: Mucinex per dosing instruction.___________________________________________

**Head Lice**: Camper must be sent home.

ADDITIONAL PRN MEDICATIONS THAT MAY BE GIVEN:
________________________________________________________________________________
MEDICATION RESTRICTIONS:
________________________________________________________________________________

List all Allergies: Food_________________________ Medications_____________________________
Insect stings________________ Other____________________________________________________
List any food or activity restrictions: _______________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

**Please list ALL medications (including over the counter or nonprescription drugs) taken routinely.**

| Medication | Dosage | Specific times taken each day | Purpose |
| --- | --- | --- | --- |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Attach additional pages for more medications.**

---

- ☐ Camper must keep inhaler with him at all times. (Please check if applies)
- ☐ Date of last physical exam: ____________________
- ☐ Additional information for the health care staff at Camp Hickory Hill pertinent to this registrant:

________________________________________________________________________

________________________________________________________________________

---

In my opinion, the above registrant is able to participate in an active camp program.

**X**

---

***Signature of Licensed Medical Personnel** (MD, PA, or CNP ONLY)

*(*This signature is required for any camper or for any staff member under the age of 19. By signing this form, the MD, PA or CNP is indicating they have read all four pages of this health form.*
*An electronic signature is acceptable.)*
*)*

**Date:**

Printed Name of Physician: ________________________________ Phone: __________________________
Professional Lic. Number: ____________________________________________________________________

Address:_________________________________________________________________________________

*This form is to be accurately completed and submitted 2 weeks prior to attending camp.*

Administrative Address: CAMP JUDAH 2444 N Main St., Warsaw, NY 14569 (585)308-1006
FAX: (585)786-8249 campjudah@gmail.com