

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. _____

ADDITIONAL PRN MEDICATIONS THAT MAY BE GIVEN:

MEDICATION RESTRICTIONS:

List all Allergies: Medications _____ Food _____

Insect stings _____ Other _____

List any food or activity restrictions: _____

Administrative Address: CAMP JUDAH 2444 N Main St., Warsaw, NY 14569 (585)786-2969

FAX: (585)786-8249 campjudah@gmail.com

Camper's Name: _____

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 had confirmed case of COVID. Date: _____
- Camper cannot tolerate wearing a face mask during most physical activities. (Please check if applies)
- Camper must keep inhaler with him at all times. (Please check if applies)
- Date of last physical exam: _____ (Does not need a physical to attend camp.)
- 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 fully & accurately completed and submitted prior to the onset of camp.

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