

# 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. **This form** should be filled out by the camper's parent or guardian. The **Provider form** must be filled out by the camper's personal 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.

## 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.

Camper's 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 \_\_\_\_\_ Policy # \_\_\_\_\_  
Phone # (     ) \_\_\_\_\_ In whose name? \_\_\_\_\_

**IMMUNIZATIONS** - Please attach a copy of immunizations provided by the camper's medical care provider.

Please share any further comments regarding your child's social, emotional, and/or psychological well-being and/or limitations that would be important for the staff to be aware of. This information will only be shared with the pastors, directors, health care personnel and your child's specific counselor.

Required Parent's Authorization: This health form is accurate and the camper 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 authorized camp health personnel to administer treatment as per standing order protocol and to administer any medications prescribed by my child's personal physician as listed on the Provider Health Form.

Parent/Guardian Signature

Relationship

Date

### **\*IMPORTANT! PLEASE READ:**

Please submit **PROVIDER 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.. Please list ALL medications (including over the counter or nonprescription drugs) taken regularly. Bring enough medication to last the entire time at camp. **Keep ALL medications in their original and current packaging/bottle that identifies the prescribing physician, the name of the medication, the dosage, the frequency of administration and purposes.** Attach additional pages as needed.

CAMP JUDAH 2444 N Main St., Warsaw, NY 14569 (585)786-2969 FAX: (585)786-8249 campjudah@gmail.com

CABIN:

EXAM DATE:

CAMP WEEK:

NAME: