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 nurse at camp during the week to provide for any health care needs of all campers. Your office and the camper's parents will be contacted should a health 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 authorized camp health personnel to administer treatment should your patient require it during their week at camp. (Camp health personnel meet all license and certification standards according to the New York State Sanitary Code for Overnight Camps.)

Orders for Camp Health Care

Seasonal Allergy Symptoms: Benadryl, Loratadine, Cetirizine, or Fexofenadine per dosing instruction.
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Mild Pain: Tylenol or Ibuprofen per dosing instruction.
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Bee Sting WITH anaphylactic reaction (or ANY ANAPHYLACTIC REACTION): Give Epi-pen 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:
____

CAMPER IS ALLERGIC TO: 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 regularly.

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.
- ☐ 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.)
- ☐ Please attach current immunization record.
- ☐ 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 the entire 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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