Camp Judah Part 2 Health Form
(Medical Provider)

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

Dear 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. Your office and the camper's parents may be contacted should a health situation warrant. There is a local hospital approximately 15 miles away where emergency services are available. 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 end of this form will authorize the 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.
_____

Mild Pain: Tylenol or Ibuprofen per dosing instruction.
_____

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. ___

Persistent Cough: Mucinex per dosing instruction. _____

ADDITIONAL PRN MEDICATIONS THAT MAY BE GIVEN:
_____

Current Known Allergies: Medications_____ Food _____

Insect stings_____ Other_____

List any food or activity restrictions: _____
_____
_____

CAMP JUDAH 2444 N Main St., Warsaw, NY 14569 Phone: (585)786-2969 Email: campjudah@gmail.com
Regular Fax (except during week of camp): (585) 786-8249 Fax during week of camp only: (585) 687-4624

Camper's Name: _____DOB:_____

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

Medication	Dosage	Specific times taken each day	Purpose

Attach additional pages as needed.

- ☐ Camper may 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 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 NP ONLY)

This signature is REQUIRED for **any and **every** camper or for any staff member under the age of 19.*
By signing this form, the MD, PA or NP is indicating they have read the entire health form.
An electronic signature is acceptable. **Today's Date:** _____

Printed Name of Physician: _____ Phone: _____
Professional Lic. Number: _____

Address:_____

This form must be fully & accurately completed and submitted prior to the onset of camp.
Admin. Address: CAMP JUDAH 2444 N Main St., Warsaw, NY 14569 Email: campjudah@gmail.com

Regular Fax (except during week of camp): 585-786-8249

Fax during week of camp only: (*June 29 – July 5, 2024*): 585-687-4624