Week Attending__________

# CAMP MISSION MEADOWS HEALTH AND EXAMINATION FORM

Cabin #______

PO Box 42, Dewittville, NY 14728 (716) 386-5932 fax (716) 386-6558

***Please be thorough in completing this Health Form. All participating campers must have a physician's signature to attend Mission Meadows. Thank you!***

Name _____________________________________________ Birth date ____/____/____

Name Parent/Guardian ________________________________Day Phone_____________

Address___________________________________________ Eve Phone _____________

City _______________________ State__________________ Zip __________________

**Emergency Contact:** (other than parent)

Name ______________________________ Relationship to camper __________________

Day Phone ___________________________Eve Phone_____________________________

Name _______________________________Relationship to camper__________________

Day Phone ___________________________Eve Phone ____________________________

**Health Ins. Company** ________________________Policy and/or Group #_____________

Name of Insured ______________________ ID# or SS# of Policy Holder_____________

**Health History:** If yes, please check, give approximate month/s and year/s, and, in order to assist MM to provide effective care, please provide additional information as appropriate

Diabetes ____/____ Serious Injury____/____ Infectious Diseases ____/____

Seizures ____/____ Heart Condition____/____ Stomach Upsets ____/____

Surgery ____/____ Headaches ____/____ Ear Infections ____/____

Major Orthodontia Work _____/____ Glasses YES NO Contacts YES NO

Emotional/Behavioral Issues:_________________________________________________

_____________________________________________________________________________

Other________________________________________________________________________

_____________________________________________________________________________

Allergies - Specify:__________________________________________________________

*Youth and Adults with Bee Sting Allergies should bring their own Bee Sting Kit and give it to the Nurse to place in the MM Infirmary.*

Currently on Allergy Desensitization Program? YES NO

Does camper usually take any medication that is being discontinued for summer/camp week?

If yes, please explain _______________________________________________________

Sleep Disturbance History (bedwetting, sleep walking, nightmares) on regular basis?

If yes, please explain _______________________________________________________

**For Females:** Has she menstruated? YES NO

If yes, is her menstrual History normal? ___ If no, does she know about it? ____

**Please Complete Reverse Side - Physician's Signature Required!!**

Other Special Considerations:______________________________________________________

_____________________________________________________________________________

**Immunization History:** New York State mandates that immunization dates must be provided to Mission Meadows, **and be updated each year** by parents! Fill in most recent date of any immunizations child has received.

Diphtheria, Pertussis, Tetanus (DPT) ____/____/____ Tetanus Booster ____/____/____

Measles, Mumps, Rubella (MMR) ____/____/____ Poliomyelitis (OPV) ____/____/___

Haemophilus influenza type B (HIB) ____/___/____ Hepatitis B (HepB) ___/___/___

Varicella (Chicken Pox) ___/___/___ Meningococcal (meningitis)___/___/___

## Parent/Legal Guardian Authorization - Signature Required

My signature below indicates the previously named camper has permission to engage in all camp activities (unless noted otherwise) on and off camp grounds, and to be transported to, and to participate in, outings and field trips off Mission Meadows grounds (including swimming), under supervision of Mission Meadows staff.

I hereby give permission to the camp staff to provide routine health care for this camper and if the camp staff deem it advisable for the welfare of this child, I authorize them to obtain services of medical professionals and to provide necessary related transportation. I authorize any physician and any hospital, through its medical staff, to take appropriate measures. I understand that I am responsible to pay for my child's medical care, including any emergency care authorized in this section. I agree to the release of these records for insurance purposes and/or as requested by a physician for the care of my minor child. The camp will make reasonable efforts to notify parents promptly if measures other than routine care are taken. I understand all medications, including over-the-counter, must be kept in the nurse's office.

I give permission to photograph and record this child and to use his/her images and sound prints in promotional materials for Mission Meadows.

I understand that campers are expected to comply with camp rules, and any camper disregarding camp rules is subject to being sent home with no refund of camp fees.

Signature of parent/guardian___________________________________ Date __________

## Camper Agreement – Signature Required

I understand the importance of, and will adhere to, camp safety regulations and the directions given to me by camp leaders so they can provide me and all campers with a safe, pleasant and memorable camp experience. I will be sure to give all medications to the nurse. I understand that if I fail to follow camp rules, I may be sent home.

Signature of camper ________________________________________ Date ___________

**Please Complete Reverse Side - Physician's Signature Required!!**

## PHYSICIAN MUST COMPLETE AND SIGN ENTIRE SIDE OF FORM!

INDIVIDUALIZED ORDERS for:_______________________________________________ Date of Birth: ____/____/____
(Camper Name)

**Standard Over-the-Counter/PRN Medications listed below** are available in infirmary and will be administered at the discretion of an RN**, if approval is indicated by the camper's physician**.

| **Drug Name**<br>Please indicate which meds can be dispensed to this camper by camp nurse. Dosage and schedule will be per label by age and weight, unless otherwise noted. | Healthcare Provider Order | Dosage | Schedule | Comments |
|---|---|---|---|---|
| Acetaminophen (Tylenol) | YES NO | | | |
| Ibuprofen (Advil) | YES NO | | | |
| Diphenhydramine (Benedryl) | YES NO | | | |
| Pseudoephedrine Hydrochloride (Sudafed) | YES NO | | | |
| Guifenison (Robitussin) | YES NO | | | |
| Chlorpheiramine (Chlortrimeton) | YES NO | | | |
| Calcium Antacid Tablets (reg) (Tums) | YES NO | | | |
| Loperamide (Immodium) | YES NO | | | |
| Triple Antibiotic Ointment | YES NO | | | |
| Burn Ointment | YES NO | | | |
| Calamine Lotion | YES NO | | | |
| Hydrocortisone 1% | YES NO | | | |
| External Analgesic (Ben Gay, Icy Hot) | YES NO | | | |
| Sting Eze for insect bites | YES NO | | | |

**Prescription Medications and camper supplied non-prescription medications and vitamins/supplements.**
Please complete with patient's current regimen for scheduled and PRN medications, and vitamins/supplements. Use second page if needed.
**All medications must be in original containers, and will be kept in the health office.**

| Drug Name | Dosage | Route | Schedule & Indications | Comments |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| Vitamins/supplements | | | | |
| | | | | |

**PHYSICIAN'S SIGNATURE REQUIRED FOR ANY MEDICATIONS OR VITAMINS/SUPPLEMENTS**.

Date Examined: __________________ Ht. ______________ Wt. ______________lbs. Blood Pressure ______________________

Limitations or Restrictions at Mission Meadows: ________________________________________________

Is camper following a medically prescribed meal plan or restriction? NO YES (if yes, attach written description)

Additional needs or information ________________________________________________

**Physician's Printed Name** ______________________________________ **Phone**__________________________

**Address** ________________________________________________

**Physician's Signature**________________________________________________ **Date** __________________