Week Attending_____

CAMP MISSION MEADOWS HEALTH AND EXAMINATION FORM

Cabin #_____

5201 Route 430, Dewittville, NY 14728 (716) 386-5932 fax (716) 954-0212

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_____

_____

Dietary Restrictions – Specify:_____
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!!

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)___/___/___

Additional Information: Please note any additional information that you feel the nurse should be aware of.

_____

_____

_____

_____

_____

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.

Parent/Guardian Signature _____ 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 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			
Phenylephrine HCL (Sudafed sub) >12 yrs	YES NO			
Guifenison (Robitussin)	YES NO			
Chlorpheniramine (Chlortrimeton)	YES NO			
Calcium Antacid Tablets (reg) (Tums)	YES NO			
Loperamide (Immodium) 1 "m" >12yrs	YES NO			
Triple Antibiotic Ointment	YES NO			
Calamine Lotion	YES NO			
Hydrocortisone 1%	YES NO			
External Analgesic (Ben Gay, Icy Hot)	YES NO			
Fiber Tablet	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 _____