



Health History and Medication Authorization

PO Box 228, Speculator, New York 12164
518.548.5277 Fax: 518.548.6333

- Return **completed** form to Deerfoot Lodge at least 4 weeks before the camper arrives.
- Keep a copy of the completed form for your records; note changes, which occur and inform Health Center staff of these changes.
- Notify Deerfoot Health Center if camper is exposed to a communicable disease within 3 weeks of starting camp.

Name _____
Last First Initial

Age _____ Birth Date _____ Phone _____
Area Code / Number

Permanent Address _____
Number & Street

City State Zip Country

Mother or Guardian _____ Home Phone _____ Work Phone _____
Address _____ Cell Phone/Pager _____
(If different from camper)

Father or Guardian _____ Home Phone _____ Work Phone _____
Address _____ Cell Phone/Pager _____
(If different from camper)

EMERGENCY CONTACT other than Parent or Guardian

Name _____ Relationship to Camper _____ Phone _____

Address _____ Cell Phone _____
Number & Street City State Zip Area Code / Number

HEALTH HISTORY

Allergies: Check all that apply

- No known allergies
 Food Insect Stings Seasonal Poison Ivy Medication/s _____

Chronic Concerns: Check all that pertain to camper.

- No chronic health concerns
 Chronic concerns
 Asthma Headaches/Migraines Sleep problem Surgery history _____
 Diabetes Back pain or injury Head injury _____
 Seizure disorder _____ Other _____

Medication: Medical Provider must complete Medication Authorization portion of this form **annually**. ALL DAILY medication, prescription or Over-the-Counter, MUST be packaged as a unit dose for the camper with appropriate labels; other medications must be in original container. International campers: Please translate medical information into English before leaving your country.

Name of Medical Provider: _____ Office Phone: (____) _____

Name of Dentist/Orthodontist: _____ Office Phone: (____) _____

Do you have family medical insurance? Yes No IF YES, PLEASE ATTACH A COPY OF INSURANCE CARD IN BOXES

Important – This Box Must be Completed Annually for Attendance

This health history is correct so far as I know, and the person herein described has the permission to engage in all camp activities except as noted. **Authorization for Treatment:** I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, treatment; to release any records necessary to the camp nurse or for insurance purposes; and to provide or arrange necessary related transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization for the person named above. **Authorization for Administration of Medications:** I also give permission for my child to receive medications at camp as prescribed by my child's medical provider, as well as reciprocal release of information between the camp nurse and the prescribing professional. This completed form may be photocopied for trips out of camp.

Signature of parent or guardian _____ Date _____

Name: _____

Session: _____

Section: _____

Year: 2012

Health Care Recommendations by Licensed Provider

I have examined camp applicant, _____ within the last 2 years. Date Examined _____

In my opinion, the above condition does does not preclude his participation in a very active camp program.

Height _____ Weight _____ Blood Pressure _____

Allergies:

_____ No known allergies

_____ Food _____ This causes anaphylaxis? Yes No

Describe the reaction(s) and management: _____

_____ Medication/s _____ This causes anaphylaxis? Yes No

_____ Substances _____ This causes anaphylaxis? Yes No

Describe the reaction(s) and management _____

Chronic Concerns: check all that pertain to camper

_____ No chronic health concerns

_____ Chronic concerns

Asthma Headaches/Migraines Sleep problem Surgery history _____

Diabetes Back pain or injury Knee or ankle weakness Head injury

Seizure disorder _____ Other _____

Current Treatment (include current medications) _____

Explanation of any reported loss of consciousness, convulsion, or concussion _____

Mental and Emotional Health:

Attention Deficit diagnosis (ADHD, ADD) Yes No

Psychiatric diagnosis: anxiety, depression, OCD, ODD Yes No _____

Learning disability type _____

Current treatment and medications _____

Recommendations and restrictions while at camp

Any treatment to be continued at camp _____

Any medically prescribed meal plan or dietary restrictions _____

Activities to be encouraged or limited _____

Immunization History

New York State Requires Completion. Legal waiver must be signed for conscientious exemption

Type of Vaccine	1 st Dose Mo/Yr	2 nd Dose Mo/Yr	3 rd Dose Mo/Yr	4 th Dose Mo/Yr	5 th Dose Mo/Yr
Diphtheria, Tetanus and Pertussis (DtaP, DTP)					
Diphtheria and Tetanus (DT) Ped formulation (< 7 yrs)					
Tetanus and Diphtheria (Td) or Tdap					
Polio (IPV,OPV)					
Measles, Mumps and Rubella (MMR)					
Hepatitis B (HBV)					
Varicella (Chickenpox)					
Hepatitis A					
Meningococcal					

Licensed Provider Authorization for Administration of Medication

Required: All medications must be pre-packaged by unit dosage. Deerfoot Lodge is registered with GroupRX Medication Management and recommends this pharmaceutical service. www.grouprx.net

Camper Name _____ Section _____

I have prescribed the following prescription medication for this camper and request the dosages be given during camp:

Prescription Medication

Diagnosis	Medication	Dosage	Frequency

Special Instructions: _____

If medication is to be given as needed, please explain when it should be given: _____

Over-the Counter Medication

The following non-prescription medications are stocked in the Health Center and are used on an as needed basis to manage illness and injury. **Medical Personnel:** Please check those items the camper should not be given.

Analgesics	No	Cough Medication	No		No
Tylenol		Delsym		Tums	
Ibuprofen		Robitussin CF		Zantac	
Excedrin		Decongestant	No	Otic	No
Cepacol Throat Lozenges		Allergy/Sinus Caplets		Swim Ear Drops	
Chloraseptic Throat Spray		Day-time Cold Caplets		Topical	No
Antihistamine	No	Dimetapp		Bacitracin Ointment	
Benadryl		Night-time Cold Capsules		Benadryl Spray	
Claritin		Gastro-Intestinal	No	Biofreeze	
Mucinex		Dramamine		Calamine Lotion	
Zyrtec		Imodium		Hydrocortisone Cream	
		Maalox		Neosporin Ointment	

Licensed Provider Signature _____ **Date** _____

Physician Name (print) _____

Address _____ **Phone** _____

Number & Street
City
State
Zip
Area Code / Number

