**Camp Name: Patterson Recreation** **Camp Year:**

**Mailing Address: PO Box 278 Patterson NY 12563**
**Phone:** 845-878-7200 Fax: 845-878-7232
**Summer Camp Address: 65 Front Street Patterson NY 12563** **(From to )**
**Phone #: 845-878-7200**
**Email: pattersonrec@gmail.com**

# REQUIRED MEDICAL HISTORY

**(Parent or Legal Guardian to Complete)**

**Please Check One:** ( ) Returning Camper ( ) New Camper ( ) Returning Staff ( ) New Staff

Session:

**Name** _____ **Date of Birth:** _____
**Address**_____ **Phone#:** _____
_____

**Emergency Notification:**

With whom does child reside and what is / are his / her relationship(s) with the child?_____
Parent 1 Name_____ Phone: Home _____ Work _____ Cell _____
Parent 2 Name_____ Phone: Home _____ Work _____ Cell _____

Person to contact in an emergency if parents are unavailable:
Name:_____ Phone: Home_____ Work_____ Cell _____
Physician:_____ Phone_____
Dentist/Orthodontist:_____ Phone_____

**Emergency Medical Information** (check yes or no)

**Yes___ No___** Allergy to a medicine, food, plant, animal, or insect
**Yes___ No___** Do you have an epinephrine pen?
**Yes___ No___** Any condition that requires special care, medication or diet
**Yes___ No___** Asthma
**Yes___ No___** Contact Lenses
**Yes___ No___** Seizure Disorder
**Yes___ No___** Diabetes
**Yes___ No___** Heart Trouble
**Yes___ No___** Bleeding Disorder
**Yes___ No___** Dentures
**Yes___ No___** Bonded Teeth

Explain any of the above:_____
_____

**Medical History** (check yes or no)

| | Yes | No | Date | Details |
|---|---|---|---|---|
| Serious illness | _____ | _____ | _____ | _____ |
| Serious injury | _____ | _____ | _____ | _____ |

**Does your child have frequent:** (circle yes or no)

**Y / N** Eye Infections **Y / N** Respiratory Infections
**Y / N** Ear Infections **Y / N** Urinary Tract Infections
**Y / N** Throat Infections **Y / N** Vaginal Infections

**Does your child have:** (circle yes or no)

**Y / N** Heart Murmur **Y / N** Menstrual Problems
**Y / N** Rheumatic Fever **Y / N** Hernia
**Y / N** Stomach/Intestinal Problems **Y / N** Back or Joint Pains

Explain any of the above:_____
Has this person had Chicken Pox? ( ) Yes ( ) No If yes, when? Date_____
Has this person had Mumps? ( ) Yes ( ) No If yes, when? Date _____
Has this person been exposed to a contagious disease within the past three weeks? _____
Has this person had lice in the past six months? _____
If applicable, has this person started menstruation? ( ) Yes ( ) No Has she been told about menstruation? ( ) Yes ( ) No
Does this person take <u>any</u> medication on a regular basis? Yes _____ No _____
Explain:_____

**Family Insurance Information:** Please send a copy of both the front and back of all Health Insurance and Prescription Cards so they can be submitted at time of service to save you money.

Policy Holder_____ Carrier_____
Policy Number_____ Address_____
Does this policy include dental coverage? Yes_____ No_____

**To the best of my knowledge, the above information is correct. I give my child permission to participate in all camp activities and trips. In the event of accident or illness, I authorize the Camp to institute and obtain medical care.**
**** In the event of a communicable disease outbreak, I understand this person will be excluded from camp if not fully immunized.**

**DATE**_____ **SIGNATURE (parent or legal guardian)**_____

# MEDICAL EVALUATION



**(To be completed by physician)**

Name_____Date of Birth_____ has had a complete history and physical exam on_____
Month/Day/Year Month/Day/Year

## Screening / Test Results

| | | |
|---|---|---|
| Height: | **BMI:** | **Vision/Type of Screening** |
| Weight: | □ Normal | With Glasses R 20 / L 20 / |
| Blood Pressure: | □ Abnormal | With out Glasses R 20 / L 20 / |
| Pulse: | Min: | |
| HCT/Hgb: | Slight: | **Auditory /Type of Screening** |
| Urinalysis: | Mod: | Right Pass / Fail |
| Gross Dental: | Marked: | Left Pass / Fail |
| Lead (Date/Result): | □ Referral to: | |

| | | |
|---|---|---|
| **TB:** In high-risk group? □ yes □ no | | |
| **TB & other Test Results:** (Sickle Cell, etc.) | | |
| **Test** | **Date** | **Result** |
| | | |
| | | |

## Disease Assessment

| Yes | No | | | Date of Onset |
|---|---|---|---|---|
| □ | □ | Asthma | □ Mild □ Moderate □ Severe □ Exercise Induced □ Unclassified | |
| □ | □ | Diabetes | □ Type I □ Type II | |
| □ | □ | Anaphylactic Reaction | □ Food □ Insect □ Latex □ Other: Explain | |
| □ | □ | Seizure Disorder | Type: | |
| □ | □ | Chicken Pox | If yes, when? | |
| □ | □ | Mumps | If yes, when? | |
| □ | □ | Other: Please Specify | | |

## Immunization History

**(Please provide month, day and year of immunization)**

| Vaccine | Dose 1 | Dose 2 | Dose 3 | Dose 4 | Dose 5 | Dose 6 |
|---|---|---|---|---|---|---|
| DPT / Hib | | | | | | |
| DTaP | | | | | | |
| DT / Td | | | | | | |
| OPV | | | | | | |
| IPV | | | | | | |
| MMR | | | | | | |
| HiB | | | | | | |
| Hep B | | | | | | |
| Hep A | | | | | | |
| Varicella | | | | | | |
| TDap | | | | | | |
| PCV | | | | | | |
| HPV | | | | | | |
| MCV | | | | | | |
| Influenza | | | | | | |

**Prescription Medication:** Please complete with patient's current regimen for both scheduled and PRN medications including heparin flushes for central lines; please use additional paper if needed.

**DRUG** **ROUTE** **DOSAGE** **FREQUENCY** **COMMENTS**

_____

_____

_____

_____

**Individualized Orders:** The following Standard "Over the Counter / PRN Medications " are available in the Health Center to be administered if needed per the family physician's instructions.

*** * * THIS SECTION MUST BE COMPLETED * * ***

| **Drug Name** (Generic equivalents may be used) | **Dosage** | **Route** | **Indications** | **Healthcare Provider Permission** | **Comments** |
|---|---|---|---|---|---|
| Diphenhydramine | As per pkg by wt. & age | PO | Allergies or Allergic Reactions | Yes / No | |
| Burn Gel | Apply to minor burns | Topically | Minor Burns | Yes / No | |
| Stool Softner | As per pkg by wt. & age | PO | No BM x 3 Days | Yes / No | |
| Acetaminophen | As per pkg by wt. & age | PO | Temp. $\geq$ 100°F or Pain | Yes / No | |
| Ibuprofen | As per pkg by wt. & age | PO | Temp. $\geq$ 100°F or Pain | Yes / No | |
| Hydrocortisone | Apply to effected area 3x/day | Topically | Itch | Yes / No | |
| Cough Drops | As per pkg by wt. & age | PO | Cough or Sore Throat | Yes / No | |
| Antacid | As per pkg by wt. & age | PO | Upset Stomach | Yes / No | |
| Antibiotic Oint. | Apply to effected area 3x/day | Topical | Scrapes or Cuts | Yes / No | |

This form is not exhaustive or restrictive. It is meant by the Putnam County Health Department only as a guide.

Please note, ***if the provider has not circled yes, it means no.*** Following the above without the provider's explicit direction is practicing medicine without a license.

**Emergency Medications:**

Does this person require: Epi-pen: □ yes □ no PRN Inhaler: □ yes □ no

This person has permission to carry: Epi-pen: □ yes □ no PRN Inhaler: □ yes □ no

(Note: ability to carry implies ability to self administer)

**Additional Orders:** As deemed necessary by health care provider to be implemented by an R.N. (i.e. peak flows, blood draws/lab work, dressing changes, cast care, feeds via GT, etc.):_____

_____

_____

**Limitations on Activities:** **S**wimming_____Diving_____Hiking_____Athletics_____Other:_____

Explain above:_____

**HIPPA Privacy Statement: Permission to Release Confidential Health Information**

I give _____permission to release confidential health information to

Name of Medical Practice

_____ regarding this person_____

Name of Camp Name of Camper or staff member

Date:_____ Parents/Guardian Signature:_____

**I certify that I have on this date examined the above named camper and that on the basis of my examination and the medical history as furnished to me, I have found no reason which would make it medically inadvisable for this camper to participate in physically strenuous activities.**

Signature of Physican_____Date of Examination_____

Please Print: Physician's Name_____License# _____

Address_____ Phone#_____

Parents Signature: _____Date: _____

# Update to Health Form

Please note any changes to medication since the "Required Medical History" forms were submitted. Be sure to note changes in dose (strength or number of mgs) or the number of times per day that a medicine is taken even of medicines that were on the original health form.

**Any changes must be signed for by the prescriber!**

| Medication Name | Dose | Frequency | Route |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Remember camper can not receive vitamins, supplements, herbal preparations or homeopathic remedies without a prescription.

Note any changes in the campers physical or medical condition since the original health form was submitted.

**Medical Change or Condition:**

Date of Onset: _____ Condition; _____
Date of Onset: _____ Condition; _____
Date of Onset: _____ Condition; _____
Date of Onset: _____ Condition; _____
Date of Onset: _____ Condition; _____

**Consent of Physician:**

Signature of Physican_____Date of Examination_____

Please Print: Physician's Name_____License# _____

Address_____ Phone#_____

**Consent of Parent/Guardian:**

Parents Signature: _____Date: _____

PC EHS/jmg
MB:Medical Form 2010