Camp L'man Achai

4405 13th Avenue Brooklyn, NY 11219 (718) 436-8255 Fax: (718) 438-6636
Campsite: 1590 Perch Lake Road Andes, NY 13731 (845) 676-3996 Fax: (875) 676-4681

Confidential Medical and Consent Form

Camper's Last Name _____ First Name_____

Address _____

City _____ State _____ Zip Code _____Date of Birth_____/_____/_____

Health Insurance Company _____ Policy / Group ID #_____

Home Phone # (_____)_____ Mother's Cell Phone # (_____)_____

Father's Work # (_____)_____ Emergency Contact: Name _____

Mother's Work # (_____)_____ Relation _____

Father's Cell Phone # (_____)_____ Phone # (_____)_____

If your child has a chronic or acute medical condition, it is imperative that you speak to the camp medical director. Please call the number at the top of this form. All information will be held confidential.

TO BE COMPLETED BY PARENTS

To assist us in the care of your child, please detail any special circumstances or conditions that our medical or counseling staff should be aware of (e.g., frequent colds, headaches, stomachaches, diarrhea/constipation, vomiting, bedwetting, sensitivity to insect bites, homesickness, nightmares, sleepwalking, anxiety reactions, etc.), and what you recommend as treatment:

_____

_____

_____

Important note: The camp office MUST be notified if your child is exposed to any communicable disease during the three weeks prior to camp attendance.

PARENTS' AUTHORIZATION AND CONSENT TO TREATMENT OF MINOR TEMPORARILY SEPARATED FROM HIS PARENTS:

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted by the examining physician and me. I hereby give permission to the physician selected by the camp director to order X-rays, routine tests, and treatment for the health of 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 hospitalize, secure proper treatment for, and order injections and/or anesthesia and/or surgery for my child as named above.

I, the undersigned, parent/guardian of _____, minor, do hereby authorize Camp L'man Achai, and / or the camp director, as our agent(s) to consent to any diagnostic procedure or medical care for said child which is deemed advisable by, and is to be rendered under the general or special supervision of, any licensed physician or surgeon at any of the regional hospitals or at any other accredited hospital, when such diagnosis or treatment is rendered at said hospital.

It is understood that this authorization is given in advance of any specific need for treatment, but is given to provide authority on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment, or hospital care which the physician in the exercise of his best judgment may deem advisable.

X_____ _____ _____

Parent's signature Witness' signature Date

Check one box and sign below:

☐ My child has had the meningococcal meningitis immunization (Menomune) within the past 10 years. Date received: _____

☐ I have read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that my child will <u>not</u> obtain immunization against meningococcal meningitis disease.

X_____ _____

Parent's signature Date

Parents, please note:

If your child is coming to camp with year-round prescription medication, we must have a note from your doctor detailing the medication prescribed, the dosage, the time and frequency it should be taken, and the reasons for taking the medication. No UNLABELED MEDICATION will be dispensed. Verbal information about medication is insufficient. All medications must be kept in the infirmary.

Please make a copy of your medical insurance card, and mail it along with your form. If you have separate prescription drug coverage, make a copy of that card and mail it along as well. *If no cards are sent, you will be billed for your child's medical care and prescription drugs at regular rates.*

TO BE COMPLETED BY EXAMINING PHYSICIAN

Camper's name _____

Home address_____ City_____ State _____ Zip_____

Weight _____ Height _____

Immunization History:

Please record month and year of basic immunizations and most recent booster

Immunization	Date basic series completed	Most recent booster
DPT or DT		
Tetanus		
Oral polio		
MMR		
PPD/Mantoux		
Hepatitis A		
Hepatitis B		
Varicella		

Allergies:	Yes	No	Comments
Penicillin			
Sulfa			
Other medication			
Food allergies *List foods your child is allergic to.*			
Bee/insect bites			

Indicate if your child has ever had an anaphylactic reaction.
If yes, are you sending your child with an EpiPen? ☐ Yes ☐ No

Medical history Indicate date of illness

Chicken pox: _____/_____/_____
Measles: _____/_____/_____
German measles: _____/_____/_____
Mumps: _____/_____/_____
Hepatitis: _____/_____/_____
Pneumonia:_____/_____/_____
Other:_____

Individualized Orders

If being treated for the following,
Please make sure the camp medical staff is notified before camp begins, and indicate the condition below:

☐ Diabetes ☐ Seizures ☐ Seasonal allergy ☐ Rheumatic fever

☐ Ear infections ☐ Strep throat ☐ Asthma- If your child is being treated for asthma, please send along the tubing for the nebulizer as well as all inhalers being used.

☐ Positive PPD Date _____/_____/_____

☐ CXRay Date _____/_____/_____

Standard over-the-counter/PRN medications, available in the infirmary/first aid kit, to be administered at the discretion of Medical Director.

DRUG*	ROUTE	DOSAGE	SCHEDULE	CONTRA-INDICATED Check only if med is NOT to be given	COMMENTS
Tylenol	PO	Per label instructions by age/weight	q 6 hr prn for discomfort or elevated temp		
Ibuprofen	PO	Per label instructions by age/weight	q 4 hr prn for discomfort or elevated temp		
Robitussin	PO	Per label instructions by age/weight	q 4 hr prn for cough		
Pepto-Bismol	PO	Per label instructions by age/weight	q 30 min to 1 hr prn for diarrhea (not >8 doses/24hr)		
Mylanta	PO	Per label instructions by age/weight	TID-QID prn for gastric upset		
Dramamine	PO	Per label instructions by age/weight	½ hr before embarkation, then q 6-8 hr prn for motion sickness		
Benadryl	PO	Per label instructions by age/weight	q 6 hr prn for allergic reaction		
Sudafed	PO	Per label instructions by age/weight	q 6-8 hr for nasal congestion/ drainage		
Tums	PO	Per label instructions by age/weight	Gastric upset/heartburn		
NaphconA	Eye gtts	Per label instructions by age/weight	1-2gtts affected eye for itching/burning		
Milk of Magnesia	PO	Per label instructions by age/weight	BID-TID prn for gastric upset/constipation		
Ear drops	TOP	Per label instructions by age/weight	As indicated		
Cortisone ointment	TOP	Per label instructions by age/weight	As indicated		
Antifungal ointment spray	TOP	Per label instructions by age/weight	As indicated		

* or generic equivalent

List any medications child is currently taking:

List dates & description of operations, serious injuries, or fractures: _____

_____

Describe any mental or psychological conditions requiring medication, treatment, or special restrictions: _____

_____

Chronic or recurrent illness, and suggested treatment: _____

_____

SPECIAL RESTRICTIONS: Diet _____ Swimming_____

Strenuous activity_____ Other _____

To the best of my knowledge the information stated above is true and accurate, and it is my opinion that the camper named above is physically able to engage in all camp activities, except as noted above.

_____
Physician's signature Date

_____
Physician's name Address Office/emergency phone #

STAMP