2019 Medical and Consent Forms
Please complete by May 1st

16946 Belle Isle Drive, Cornelius, NC 28031, phone: 704-936-7459, fax: 704-842-3859 154 Gadway Rd, Merrill, NY 12955
info@campjeannedarc.com

Print out the following attached forms and complete, sign, scan, and upload to Bunk1

(Note: Each camper must be examined by a health care provider within one year of camp and must submit current medical forms prior to arriving at camp)

IMPORTANT CHECKLIST:

____Authorization for Consent to Treatment of a Minor Form, MUST BE SIGNED BY PARENT

____Individual Over-the-Counter Medication Form, MUST BE SIGNED BY PARENT AND DOCTOR

____ Meningococcal Meningitis, Immunization, and Risk & Legal Waiver, MUST BE SIGNED BY PARENT

____Camper Health-Care Report by Licensed Medical Personnel, MUST BE SIGNED BY DOCTOR

____Camper Health History (3 pages), MUST BE SIGNED BY PARENT

Camp Jeanne d'Arc

AUTHORIZATION FOR CONSENT TO TREAT A MINOR FORM

In the event that I cannot be reached in an EMERGENCY, I hereby give my consent and authorization for any emergency or non-emergency diagnostic procedure, medical, dental, surgical care/treatment and hospitalization that any health care provider so determined as advisable, in the best judgment of said health care provider including, but not limited to, physician, dentist or hospital personnel providing health care to the minor while she/he attends Camp Jeanne d'Arc/Camp Lafayette.

Print Camper's Name: _____

Print Parent's Name: _____

Parent's Signature: _____Date:_____

Relationship to Camper: _____

BEST number(s) to reach you:

_____

Home Address:

_____

_____

Health Insurance Name: (must include a copy of front and back of Insurance AND Prescription cards)

_____ _____

Group Number:_____

ID#:_____

Subscriber Name:_____

Subscriber Date of Birth:_____

_____

Front of Card	Back of Card

Copies of card (front and back) can be attached on separate page

camp jeanne d'arc

INDIVIDUAL OVER-THE-COUNTER MEDICATION FORM

Camper's Name:_____

Instructions to physician/health care provider: CROSS OUT ANY MEDICATIONS NOT TO BE GIVEN. YOUR SIGNATURE AUTHORIZES USE OF BELOW LISTED MEDICATIONS.

Physician/Health Care Provider SIGNATURE: _____ Date: _____

Parent's Signature: _____Date: _____

I give my child _____ permission to self-administer her medication in the event that a nurse is not available to do so (e.g. on an out of camp trip). **(PLEASE CROSS OUT IF YOU DO NOT CONSENT)**

Drug name	Dosage	Route	Frequency
Acetaminophen (Tylenol or other Name Brand)	As per bottle directions	PO	q 4 - 6 h PRN for minor pain or fever
Ibuprofen (Motrin, Advil or other Name Brand)	As per bottle directions	PO	q 6 - 8 h PRN for minor pain or fever
Diphenhydramine (Benadryl or other Name Brand)	As per bottle directions	PO	q 4 -6 h PRN for minor allergic reactions
Antipruritic/anti-itch/anti-pain (Benadryl, Hydrocortisone 1%, Calamine, Sting-X or other generic/Name Brand)	As per bottle directions	topically	PRN for itching
Antiseptic (Hydrogen peroxide,Isopropyl alcohol, Swimmer'sEar Dry or other generic/name brand)	As per bottle directions	topically	PRN for wound cleaning or water in ears.
Antibiotic cream or ointment (Bacitracin or other generic/Name Brand),	As per bottle directions	topically	PRN to prevent infection
Liquid Bandage (Nexcare, New Skin or other generic/name brand)	As per bottle directions	topically	PRN for wound care
Sunscreen (various brands, strengths) Sunburn analgesic (Aloe vera gel)	As per bottle directions	topically	PRN to prevent or relieve minor sunburn
Cough drops (Ricola or other generic/name brand)	As per package directions	PO	PRN for sore throat, cough
Topical Pain Relief (Water-Jel, Cool Gel or other generic/name brands)	As per package directions	topically	PRN for minor burns, scrapes or abrasions

Orders for prescription medication and/or other over the counter medicines not included in the above list. (ex. Vitamins, Herbal supplements, Laxatives)

Drug Name	Dosage	Route	Frequency

I give my child permission to carry and apply insect repellent and sunblock (circle one) YES NO

I give permission for a staff member to help my child apply insect repellent and sunblock (circle one) YES NO

camp jeanne d'arc

PART 1 - MENINGOCOCCAL VACCINATION RESPONSE FORM
It's REQUIRED by NY State law that parents check one box below. However, vaccination is not required.

CHECK ONE BOX -

☐ My child has had the meningococcal meningitis immunization within the past 10 years.

☐ My child will obtain immunization against meningococcal meningitis within 30 days from my private health care provider AND I have read, or had explained to me, the information regarding meningococcal meningitis disease.

☐ My child will not obtain immunization against meningococcal meningitis AND I have read, or had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not having my child immunized.

PART 2 - IMMUNIZATION RELEASE - CURRENT COPY OF IMMUNIZATION RECORD MUST BE ATTACHED PER NEW YORK STATE LAW

PART 3 – PARENT'S CONSENT, RISK AND LEGAL WAIVER

Camp Jeanne d'Arc (hereinafter "Camp") pledges our best efforts in providing a safe, supportive and satisfying camp experience for all. Parents specifically consent to Camper's participation in all activities sponsored by Camp, on or off camp premises, including but not limited to: swimming, boating, horseback riding (if applicable), water skiing (if applicable), athletic competition including bodily contact, and travel in Camp-owned and/or Camp leased vehicles. Parents understand that as part of the regular camp program, Camper may travel off the camp grounds by foot, by boat, by car, by van or by bus for such activities as nature walks, camping (including overnight,) visits to nearby places of interest, day trips and travel to and from airports, etc. All of which will be under appropriate Camp supervision.

Parents understand that there are risks of bodily injury that might result from these and other activities that are conducted by the Camp. Parents agree to release, indemnify, and hold harmless in all respects, the Camp owners, directors, counselor staff and other employees regarding claims for injuries that may be incurred as a result of participation in these activities. Camper may utilize commercial carriers that have been hired by Camp when traveling to and from Camp as well as during participation in some Camp activities and trips organized by Camp. Camp is not responsible for any acts or accident of such commercial carriers. Parents understand that while on "out of camp" trips, camper may also be swimming or boating at sites that have not been inspected by the New York State Health Department.

Permission is hereby given for Camp to use photographs, statements, articles, music, art, films and video of or by the Camper for the use, enjoyment and promotion of the Camp. (Note: we do not "tag" anyone under 18 in any of our social media posts.)"

Parent Signature: _____Date: _____
(Legal Guardian)

Recommendations for Licensed Medical Personnel

Developed and reviewed by: American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses

american CAMP association®

Mail this form to the address below by (date)

Camper Health Care Report

To Parent(s)/Guardian(s): Complete this section and give this form (FORM 2) and a copy of your completed CAMPER HEALTH HISTORY FORM (FORM 1) to your child's health-care provider for review. Dates will attend camp: from _____to_____
Month/Day/Year Month/Day/Year

Camper Name: _____
First Middle Last

☐ Male ☐ Female Birth Date _____ Age on arrival at camp _____
Month/Day/Year

Camper home address: _____

_____
City State Zip Code

Custodial parent(s)/guardian(s) phone: (_____)_____ (_____)_____

Parent(s)/guardian(s) stop here. Rest of form to be completed by medical personnel.

The following non-prescription medications are commonly stocked in camp Health Centers and are used on an as needed basis to manage illness and injury. ***Medical personnel: Cross out those items the camper should not be given.***

Acetaminophen (Tylenol)
Ibuprofen (Advil, Motrin)
Phenylephrine (Sudafed PE)
Pseudoephedrine (Sudafed)
Chlorpheneramine maleate
Guaifenesin
Dextromethorphan
Diphenhydramine (Benadryl)
Generic cough drops
Chloraseptic (Sore throat spray)
Lice shampoo or scabies cream (Nix or Elimite)
Calamine lotion
Bismuth subsalicylate (Pepto-Bismol)
Laxatives for constipation (Ex-Lax)
Hydrocortisone 1% cream
Topical antibiotic cream
Calamine lotion
Aloe

Medical Personnel: Please review the CAMPER HEALTH HISTORY FORM (FORM 1) and complete all remaining sections of this form (FORM 2).
Attach additional information if needed.

Physical exam done today: ☐ Yes ☐No **(If "No," date of last physical: _____)**
Month/Day/Year **ACA accreditation standards specify physical exam within the last 12 months.**

Weight: _____ lbs Height: _____ft_____in Blood Pressure_____/_____

Allergies: ☐ No Known Allergies ☐ To foods ***(list)***:

☐ To medications: ***(list)***:

☐ To the environment ***(insect stings, hay fever, etc.– list)***:

☐ Other allergies: ***(list)***:

Describe previous reactions:

Diet, Nutrition: ☐ Eats a regular diet. ☐ Has a medically prescribed meal plan or dietary restrictions:(describe below)

The camper is undergoing treatment at this time for the following conditions: ***(describe below)*** ☐ None.

Medication: ☐ No daily medications. ☐ Will take the following prescribed medication(s) while at camp: ***(name, dose, frequency—describe below)***

Other treatments/therapies to be continued at camp: ***(describe below)*** ☐ None needed.

Do you feel that the camper will require limitations or restrictions to activity while at camp? ☐ No ☐ Yes

If you answered "Yes" to the question above, what do you recommend? (describe below—attach additional information if needed)

"I have reviewed the CAMPER HEALTH HISTORY FORM (FORM 1), and have discussed the camp program with the camper's parent(s)/guardian(s). It is my opinion that the camper is physically and emotionally fit to participate in an active camp program (except as noted above.)

Name of licensed provider (please print): _____Signature: _____Title: _____

Office Address_____
Street City State Zip Code

Telephone: (_____)_____ Date:_____

CAMPER HEALTH HISTORY

Developed and reviewed by: *American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses*

Camper Name: _____
First Middle Last

Immunization History: Provide the month and year for each immunization. Starred (★) immunizations must include date to meet ACA Standard. Copies of immunization forms from health-care providers or state or local government are acceptable; please attach to this form.

Immunization	Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most Recent Dose Month/Year
Diptheria, tetanus, pertussis (DTaP) or (TdaP)						
Tetanus booster★ (dT) or (TdaP)						
Mumps, measles, rubella (MMR)						
Polio (IPV)						
Haemophilus influenzae type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox) ☐ Had chicken pox Date:						
Meningococcal meningitis (MCV4)						

Tuberculosis (TB) test	Date:	☐ Negative ☐ Positive

If your camper has not been fully immunized, please sign the following statement: I understand and accept the risks to my child from not being fully immunized.

Signature of Custodial Parent/Guardian: _____ Date:_____ Relationship to Camper: _____

Medication: ☐ This camper will not take any daily medications while attending camp. ☐ This camper will take the following daily medication(s) while at camp:

"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. ***Please review camp instructions about required packaging/containers. Many states require original pharmacy containers with labels which show the camper's name and how the medication should be given. Provide enough of each medication to last the entire time the camper will be at camp.***

Name of medication	Date started	Reason for taking it	When it is given	Amount or dose given	How it is given
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time:_____		
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time:_____		
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time:_____		
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time:_____		

CAMPER HEALTH HISTORY

Developed and reviewed by: *American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses*

Camper Name: _____
First Middle Last

General Health History: ***Check "Yes" or "No" for each statement. Explain "Yes" answers below.***

Has/does the camper:

1. Ever been hospitalized? ……..... ☐ Yes ☐ No
2. Ever had surgery? .....……..... ☐ Yes ☐ No
3. Have recurrent/chronic illnesses? .....……..... ☐ Yes ☐ No
4. Had a recent infectious disease? .....……..... ☐ Yes ☐ No
5. Had a recent injury? .....……..... ☐ Yes ☐ No
6. Had asthma/wheezing/shortness of breath?..... ☐ Yes ☐ No
7. Have diabetes? .....……..... ☐ Yes ☐ No
8. Had seizures? ..... ☐ Yes ☐ No
9. Had headaches? ……..... ☐ Yes ☐ No
10. Wear glasses, contacts, or protective eyewear? ☐ Yes ☐ No
11. Had fainting or dizziness? ..... ☐ Yes ☐ No
12. Passed out/had chest pain during exercise? ……..... ☐ Yes ☐ No
13. Had mononucleosis ("mono") during the past 12 months?..... ☐ Yes ☐ No
14. If female, have problems with periods/menstruation?……..... ☐ Yes ☐ No
15. Have problems with falling asleep/sleepwalking? ..... ☐ Yes ☐ No
16. Ever had back/joint problems?……..……..... ☐ Yes ☐ No
17. Have a history of bedwetting?……..... ☐ Yes ☐ No
18. Have problems with diarrhea/constipation?……..... ☐ Yes ☐ No
19. Have any skin problems?……..... ☐ Yes ☐ No
20. Traveled outside the country in the past 9 months?..... ☐ Yes ☐ No

Please explain "Yes" answers in the space below, noting the number of the questions. For travel outside the country, please name countries visited and dates of travel.

Mental, Emotional, and Social Health: ***Check "Yes" or "No" for each statement.***

Has the camper:

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)? ……..... ☐ Yes ☐ No
2. Ever been treated for emotional or behavioral difficulties or an eating disorder?……..... ☐ Yes ☐ No
3. During the past 12 months, seen a professional to address mental/emotional health concerns?……..... ☐ Yes ☐ No
4. Had a significant life event that continues to affect the camper's life?..... ☐ Yes ☐ No
   (History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)

Please explain "Yes" answers in the space below, noting the number of the questions. The camp may contact you for additional information.

Health-Care Providers:

Name of camper's primary doctor(s): _____ Phone: (_____) _____

Name of dentist(s):_____ Phone: (_____) _____

Name of orthodontist(s):_____ Phone: (_____) _____

What Have We Forgotten to Ask? ***Please provide in the space below*** any additional information about the camper's health that you think important or that may affect the camper's ability to fully participate in the camp program. ***Attach additional information if needed***.

Parents/Guardians: STOP here. The rest of this is form is completed when the camper arrives at camp. Keep a copy for your records.

CAMPER HEALTH HISTORY

(Camp Use Only)

Developed and reviewed by: *American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses*

Camper Name: _____
First Middle Last

Individual Health Record (For Camp Use Only)

Initial Screening Date/Time: _____Initials: _____

☐ Screening has been conducted according to camp protocol and significant findings noted as follows:

A. Any signs/symptoms of illness or injury upon arrival?..... ☐ No ☐ Yes as noted below

B. History of exposure to communicable disease?..... ☐ No ☐ Yes as noted below

C. Additions or corrections to information on this health history?..... ☐ No ☐ Yes as noted below

D. Medication given to health-care staff?.....☐ No ☐ Yes as noted below

E. Any signs/symptoms of head lice?..... ☐ No ☐ Yes as noted below

Provider notes: (date/time/initial all entries)

_____

_____ **Exit Note:** Check one of the following:

☐ Left camp this day with no reported illness or injury symptoms.

☐ Left camp this day with the following problem/concern:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

This person was told about the problem and instructed about follow-up as noted above: _____

Date/Time: _____ Initials: _____