

REQUIRED – RETURN BY MAY 1st

camp jeanne d'arc

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154 Gadway Rd, Merrill, NY 12955, phone: 518-425-3311, fax: 518-425-6673
info@campjeannedarc.com

AUTHORIZATION FOR CONSENT TO TREAT A MINOR

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: _____

List any restrictions, allergies, medications, special dietary needs, and other pre-existing medical, physical or psychological conditions and illnesses: _____

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OVER-THE-COUNTER MEDICATION FORM

Camper's Name: _____

DOB: _____ Weight: _____ Allergies: _____

Instructions to physician/health care provider: 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 ANY OF THE ITEMS BELOW IF YOU DO NOT CONSENT ADMINISTRATION

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's Ear 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

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MENINGOCOCCAL & IMMUNIZATION RELEASE FORM

PART 1 - MENINGOCOCCAL VACCINATION RESPONSE FORM

It IS required by New York State law that parents check one box below and return this form.

It is not required that campers have this vaccination.

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

CHECK ONE BOX -

- I DO NOT give permission for my child to receive any vaccinations without specific written consent while at camp.
- I hereby give permission for my child to receive any vaccinations required by the New York State Department of Health that she/he has not yet received. I understand that these vaccinations will be administered by the New York State Department of Health. I further understand that all vaccinations occasionally have serious adverse side effects.

Print Camper's Name: _____

Print Parent's Name: _____

Parent's Signature: _____

Relationship to Camper: _____

Date: _____

CAMPER HEALTH HISTORY FORM 1

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)

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

To Parent(s)/Guardian(s): Please follow the instructions below. Attach additional information if needed.

- 1) Complete **pages 1, 2 and 3** of this form (FORM 1) and **make a copy**.
- 2) Send the **original, signed FORM 1** to camp by the requested date.
- 3) Complete the top of **FORM 2 (CAMPER HEALTH-CARE RECOMMENDATIONS)** and provide the **copy of FORM 1 with FORM 2** to your **child's health-care provider** for review and completion.
- 4) After it has been **completed and signed** by your child's health-care provider, return **FORM 2** to camp by the requested date.

Camper Home Address: _____
Street Address City State Zip Code

Parent/guardian with legal custody to be contacted in case of illness or injury:

Name: _____ Relationship to Camper: _____ Preferred Phones: (____) _____ (____) _____
Relationship to Camper
 Email: _____

Home Address: _____
(If different from above) Street Address City State Zip Code

Second parent/guardian or other emergency contact:

Name: _____ Relationship to Camper: _____ Preferred Phones: (____) _____ (____) _____
Relationship to Camper
 Email: _____

Additional contact in event parent(s)/guardian(s) can not be reached:

Name: _____ Relationship to Camper: _____ Preferred Phones: (____) _____ (____) _____
Relationship to Camper

Allergies: No known allergies. This camper is allergic to: Food Medicine The environment (insect stings, hay fever, etc.) Other
(Please describe below what the camper is allergic to and the reaction seen.)

Diet, Nutrition: This camper eats a regular diet. This camper eats a regular vegetarian diet. This camper is lactose intolerant. This camper is gluten intolerant.
 Other, **please explain in space.**

Restrictions: I have reviewed the program and activities of the camp and feel the camper can participate without restrictions.
 I have reviewed the program and activities of the camp and feel the camper can participate with the following restrictions or adaptations.
(Please describe below.)

Medical Insurance Information:

This camper is covered by family medical/hospital insurance Yes No

Include a copy of your insurance card if appropriate; copy both sides of the card so information is readable.

Insurance Company _____ Policy Number _____
 Subscriber _____ Insurance Company Phone Number (____) _____

Parent/Guardian Authorization for Health Care:

This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

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

If for religious or other reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance.

Camper Name _____
First Middle Last
 (For Camp Use) Cabin or Group _____
 (For Camp Use) Session Code(s): _____

CAMPER HEALTH HISTORY FORM 1

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

Camper Name: _____
First Middle Last

Birth Date: _____
Month/Day/Year

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
Diphtheria, 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)	<input type="checkbox"/> Had chicken pox Date: _____					
Meningococcal meningitis (MCV4)						

Tuberculosis (TB) test	Date: _____	<input type="checkbox"/> Negative <input type="checkbox"/> Positive
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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
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		

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

- | | |
|---|---|
| Acetaminophen (Tylenol) | Ibuprofen (Advil, Motrin) |
| Phenylephrine decongestant (Sudafed PE) | Pseudoephedrine decongestant (Sudafed) |
| Antihistamine/allergy medicine | Guaifenesin cough syrup (Robitussin) |
| Diphenhydramine antihistamine/allergy medicine (Benadryl) | Dextromethorphan cough syrup (Robitussin DM) |
| Sore throat spray | Generic cough drops |
| Lice shampoo or cream (Nix or Elimate) | Antibiotic cream |
| Calamine lotion | Aloe |
| Laxatives for constipation (Ex-Lax) | Bismuth subsalicylate for diarrhea (Kaopectate, Pepto-Bismol) |

CAMPER HEALTH HISTORY FORM 1

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

Camper Name: _____

First

Middle

Last

Birth Date: _____
Month/Day/Year

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

Has/does the camper:

- | | | | |
|--|--|--|--|
| 1. Ever been hospitalized? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 11. Had fainting or dizziness? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Ever had surgery? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 12. Passed out/had chest pain during exercise? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Have recurrent/chronic illnesses? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 13. Had mononucleosis ("mono") during the past 12 months?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Had a recent infectious disease? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 14. If female, have problems with periods/menstruation?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Had a recent injury? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 15. Have problems with falling asleep/sleepwalking? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Had asthma/wheezing/shortness of breath?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | 16. Ever had back/joint problems?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Have diabetes? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 17. Have a history of bedwetting?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Had seizures? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 18. Have problems with diarrhea/constipation?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Had headaches? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 19. Have any skin problems?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. Wear glasses, contacts, or protective eyewear? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 20. Traveled outside the country in the past 9 months?..... | <input type="checkbox"/> Yes <input type="checkbox"/> 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)? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Ever been treated for emotional or behavioral difficulties or an eating disorder?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. During the past 12 months, seen a professional to address mental/emotional health concerns?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Had a significant life event that continues to affect the camper's life?.....
(History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others) | <input type="checkbox"/> Yes <input type="checkbox"/> No |

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.

