



Summer Medical Form

Children's Bible Fellowship of NY, Inc.  
 PO Box 670 \* Carmel, NY 10512

Phone 845-225-2005 \* FAX 845-225-2087 \* e-mail camp@cbfny.com



**Health Care Recommendations and Examination by licensed physician**

I have examined \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Date of Examination \_\_\_\_\_ Blood Pressure \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Temp \_\_\_\_\_

In my opinion, the above applicant  is  is not able to participate in a camp program. (Camp Hope's program is designed for children and adults with disabilities.)

MEDICAL HISTORY/DIAGNOSIS(ES)	PHYSICAL EXAM:			COMMENTS, SPECIAL INSTRUCTIONS, RESTRICTIONS
	Appearance	<input checked="" type="checkbox"/>	Comment	
	Head/Scalp			
	Eyes			
	Ears			
	Nose			
	Throat			
	Mouth/Teeth			
	Glands			
	Neck			
<b>Allergies:</b>	Heart			
	Lungs			
<b>Diet:</b>	Abdomen			
	Genitalia			
<b>Skin: Intact?</b>	Ano. Rectal			
<b>Pressure sore?</b>	Extrem./Hips			
<b>Rash?</b>	Neuro.			

**RESTRICTIONS/RECOMMENDATIONS FOR CAMP:**

Medications: Prescriptions/ Over the Counter:			Immunization History: This is <b>REQUIRED</b> TO BE COMPLETED FOR EVERYONE ATTENDING CAMP UNDER THE AGE OF 26. If over age 26, the dates of the last tetanus booster is required and the meningococcal vaccine is recommended.							
Name	Dosage	Frequency	Vaccine:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
			Meningococcal							
			DTP							
			TD							
			Tetanus							
			Polio							
			MMR							
			Or measles							
			Or mumps							
			Or rubella							
			Hib							
			Hepatitis B							
			Varicella							
			Other							
			TB Mantoux Test	Date of last test --- _____ Result [ ] Positive [ ] Negative						

New York State Department of Health requires orders to be individualized for each camper or staff member. Nurse cannot administer medication unless it is checked off. (ie [√]). Please note each item has space to add your own orders. All medications will be given as per label and may be generically administered unless doctor notes otherwise.

ABRASIONS, SCRATCHES, CUTS:

- [ ] Bacitracin
[ ] Triple Antibiotic Ointment
[ ] \_\_\_\_\_

HEADACHE:

- [ ] Acetaminophen
[ ] Ibuprofen
[ ] \_\_\_\_\_

SORE THROAT:

- [ ] Robitussin cough drops
[ ] Acetaminophen
[ ] \_\_\_\_\_

BEESTINGS:

- [ ] Benadryl - topical
[ ] Benadryl - oral
[ ] \_\_\_\_\_

INDIGESTION:

- [ ] Maalox
[ ] Notify local physician/ emergency room if no relief from indigestion or if pain is accompanied by abdominal tenderness, fever, or excessive vomiting.
[ ] \_\_\_\_\_

SPLINTERS:

- [ ] Betadine Ointment to splinter site
[ ] Triple antibiotic ointment to splinter site
[ ] \_\_\_\_\_

BURNS (mild): First degree (redness only)

- [ ] AloeVera Ointment
[ ] Solarcaine
[ ] \_\_\_\_\_

INSECT BITES (ie mosquito)

- [ ] Calamine
[ ] Benadryl Spray or gel
[ ] Apply Hydrocortisone ointment 1%
[ ] To relieve local swelling Diphenhydramine
[ ] \_\_\_\_\_

SPRAINS, STRAINS

- [ ] Ibuprofen
[ ] Acetaminophen
[ ] \_\_\_\_\_

COMMON COLD:

- [ ] Acetaminophen
[ ] Advil cold + sinus
[ ] Dayquil
[ ] Nyquil
[ ] Dimetapp Cold
[ ] Vitamin C
[ ] \_\_\_\_\_

MENSTRUAL CRAMPS

- [ ] Acetaminophen
[ ] Ibuprofen
[ ] Midol / Pamprin
[ ] \_\_\_\_\_

SUNBURN:

- [ ] A&D Ointment
[ ] Aloe Vera gel/lotion
[ ] Solarcaine
[ ] Acetaminophen
[ ] Ibuprofen
[ ] \_\_\_\_\_

CONSTIPATION:

- [ ] Prune juice
[ ] Milk of Magnesia
[ ] If no relief in 24 hours, give Fleets Enema
[ ] \_\_\_\_\_

RASH FROM POISON IVY, POISON SUMAC, OR POISON OAK:

- [ ] Ivarest cream
[ ] Calamine Lotions
[ ] \_\_\_\_\_

TEMPERATURE ELEVATION (FEVER):

- [ ] Acetaminophen
[ ] Ibuprofen
[ ] \_\_\_\_\_

DIARRHEA:

- [ ] Kaopectate
[ ] \_\_\_\_\_

TOOTHACHE:

- [ ] Acetaminophen
[ ] Ibuprofen
[ ] Alleve
[ ] \_\_\_\_\_

EARACHE:

- [ ] Acetaminophen
[ ] Ibuprofen
[ ] \_\_\_\_\_

SHORTNESS OF BREATH::

- [ ] For severe dyspnea, give Oxygen
[ ] \_\_\_\_\_

Orders valid from \_\_\_\_\_ through \_\_\_\_\_.

Licensed Physician's signature \_\_\_\_\_ Date \_\_\_\_\_

Print clearly or stamp:
Name
Title
Address
Phone number in event nurse must contact MD for further orders
Fax

**Emergency Information, Consents and Health History**

Name \_\_\_\_\_  Male  Female  
Last First MI Date of Birth

Diagnosis(es) \_\_\_\_\_  
 \_\_\_\_\_

Address \_\_\_\_\_ Apt. \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_

**Custodial Parent/Guardian or Primary Emergency Contact**

(If applicant is an independent adult, please list person to contact in event of emergency)

Name _____	Relationship _____
Address and phone number (if different from above) _____	
_____	

**Emergency Contacts** (to be used if above contact cannot be reached in an emergency. Please list at least two.)

Name	Relationship	Phone Number(s)

**Social Security Number** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Health Insurance.** Is the camper covered by family medical/hospital insurance or Medicaid?  Yes  No

**\*\*You MUST attach a copy of BOTH SIDES of your insurance card(s) or benefit card(s).\*\***

NY Medicaid \_\_\_\_\_

Medicare \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Medicare Part D information \_\_\_\_\_

Please complete below for all other insurance coverage

Insurance Company	Policy Holder	Policy Number	Effective Date

**Treatment and Emergency Care Authorization**

(must be signed by parent/guardian or adult camper or staff member)

1. I give permission to the camp to provide routine healthcare, to administer prescribed medications and provide emergency care. I give permission for health center staff to obtain results of tests and x-rays.

2. In the event I cannot be reached in an emergency, I give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the applicant. I agree to the release of any records necessary for insurance purposes. I give permission to the camp to arrange necessary related transportation for the individual listed above.

3. I give permission for the above named individual to go into the adapted swimming pool with adequate supervision.  
 Please check one:  Yes  No

4. This health history is correct and complete as far as I know.

Signature of parent/guardian or adult camper/staff member \_\_\_\_\_

Date \_\_\_\_\_

### Health History

Please answer each of the following questions and explain all "yes" answers on the lines below or on an attached sheet, especially chronic illnesses or recent surgery. Has the camper (had):

1. Any injury, illness, hospitalization including any trip to the emergency room, surgery or infectious disease within the last six months?  Yes  No
2. Chronic or recurring illness/condition other than disabilities listed?  Yes  No
3. Surgery? (list)  Yes  No
4. Frequent headaches?  Yes  No
5. Head injury?  Yes  No
6. Wear glasses or contacts?  Yes  No
7. Have frequent ear infections?  Yes  No
8. Passed out, experienced dizziness or chest pain during exercise?  Yes  No
9. High blood pressure?  Yes  No
10. Heart murmur?  Yes  No
11. Back problem?  Yes  No
12. Bleeding or clot disorders?  Yes  No
13. Allergic reaction to latex  Yes  No
14. Problems with joints? (eg knees, ankles)  Yes  No
15. Orthodontic appliance being brought to camp?  Yes  No
16. Hearing Aid  Yes  No
17. Skin problems (eg itching, rash, acne, sores or decubitus ulcers)?  Yes  No
18. Diabetes?  Yes  No
19. Asthma?  Yes  No
20. Diarrhea or constipation?  Yes  No
21. Sleepwalking?  Yes  No
22. Abnormal menstrual history?  Yes  No  Not applicable
23. Recent history of bedwetting?  Yes  No
24. Eating disorder?  Yes  No
25. Emotional difficulties for which help was sought?  Yes  No

26. History of seizures (other than in infancy?)  Yes  No Date of last seizure \_\_\_\_\_

If yes, please give the type(s) of seizure, describe seizure activity, warning signs, duration, special precautions, etc.

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Which of the following has the camper had?

\_\_\_Measles \_\_\_Chickenpox \_\_\_German Measles \_\_\_Mumps \_\_\_Hepatitis A \_\_\_Hepatitis B \_\_\_Hepatitis C

Health related information for camp personnel. (Please explain any specific instructions or techniques used in the applicant's care; Include precautions, restrictions, etc.)

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Medication, Food or other Allergy	What is the reaction and how is it managed?

**Personal Physicians** (Please list all physicians and dentists providing follow-up care or prescribing medication for the camper.)

Physician's Name	Phone Number	Specialty

Name of person who completed form \_\_\_\_\_ Relationship to camper \_\_\_\_\_

Date health history and permission completed (within six months of attendance at camp) \_\_\_\_\_