



Mail to Camp 2010 Medical Form

Please circle session(s) attending: 1 2 3 4 5 6

Adventure Trip _____

Parents may not leave their child without this form completed and submitted.

Please keep a copy for your records

Name _____ Birth date _____ Sex _____ Age _____
Last First MI

Home Address _____
Street and Number City State Zip

Mother's Name _____ Occupation _____

Home Phone _____ Business Phone _____

Father's Name _____ Occupation _____

Home Phone _____ Business Phone _____

Parents' Cell Phone(s) _____ Beeper _____

Email _____

Will you be on vacation while your child is at camp? _____ How do we reach you? _____

If not available in an emergency, notify: Name and Phone(s) _____

If parents are divorced or separated, who has custody? _____

Operations, serious injuries, or diseases (dates) _____

Chronic or recurring illness or medical condition _____

Dietary restrictions _____

Does your child wet the bed? _____ How is it handled at home? _____

For female campers: Has camper menstruated? _____ Any difficulties? _____ If not, has she been told about it? _____

Name of family physician _____ Phone _____

Name of dentist/orthodontist _____ Phone _____

Family or camper's medical/hospital insurance: Carrier _____

Policy/Group # _____ Name of insured _____

Parent Agreement: This health history is correct so far as I know. I understand that Chingachgook does not carry health and accident insurance and that I am responsible for health-incurred costs. My child may attend Camp Chingachgook and engage in all camp activities except as noted on this form and the camper skill class sign-up form. He/she may participate in out-of-camp trips and swimming in possibly remote areas; and may travel by van, motorboat, bike, canoe, kayak, or hiking, understanding that he/she is under competent leadership. I also grant Camp Chingachgook and its agents full authority to take whatever actions they deem necessary regarding my child's health and safety; and I fully release the Capital District YMCA and its agents from liability in connection with those decisions.

I understand that my child must comply with camp rules and standards of behavior. I agree that Camp Chingachgook has the right to enforce appropriate standards of conduct, and that Chingachgook may dismiss, without a refund, any camper who infringes on the rights of others. Further, I give permission for the use of any photographs, slides, or videotapes that may include my child to be used in YMCA promotional materials.

Meningococcal Meningitis Response: Please refer to page 5 and check the appropriate circle below:

- My child has had the meningococcal meningitis immunization (Menomune™) within the past 10 yrs. Date received: __ __
Note: the vaccine's protection lasts for approximately 3 – 5 years. Revaccination may be considered within 3 – 5 years.
- 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 **not** obtain immunization against meningococcal meningitis.

Authorization for treatment and medication: I hereby give Camp Chingachgook permission to act on behalf of my child for treatment at a medical facility and to provide or arrange necessary related transportation. In the event I cannot be reached in an emergency, I hereby give permission to the attending physician to secure and administer treatment for my child, including x-rays, injections, routine tests, and hospitalization. In the event of a minor medical need, the camp staff have my permission to administer over-the-counter medications to my child according to the directions on the label. Examples include Cepacol lozenges, Ibuprofen, Maalox, Mylanta, Sudafed, Tylenol, Benadryl, Pepto-Bismol, Robitussin, hydrocortisone cream, and sunscreen.

Signature of parent/guardian (or adult staff) _____ Date _____

Witness _____ Date _____

Patient Name _____

This form must be completed and signed by physician

Health History (dates)		Diseases (age/dates)		Allergies	
Frequent ear infections		Chickenpox		Hay fever	
Heart defect/disease		Measles		Ivy poisoning, etc.	
Convulsions		German measles		Insect stings	
Diabetes		Mumps		Penicillin	
Bleeding/clotting disorders		Asthma		Sulfa drugs	
Hypertensions		Epilepsy		Other drugs	
Mononucleosis		Diabetes		Foods*	

Immunization	Date	Immunization	Date	Immunization	Date
Tetanus only		Polio		Varicella	
DPT or TD		HIB		Measles only	
MMR		Hepatitis		Haemophilus flu type B	

Most recent tuberculin test administered (date) _____

Date examined (must have been after June 2008 to be valid) _____

Height _____ Weight _____ Blood Pressure _____

Explanation for any reported loss of consciousness, convulsion, or concussion _____

Camper is receiving medical treatment as follows for the conditions checked above _____

How is treatment to be continued at camp? _____

Describe reaction to allergies listed above _____

Describe medically prescribed meal plan or dietary restrictions _____

* Food allergies: soy tree nuts peanuts dairy gluten shell fish other _____

Activities to be encouraged _____

Activities to be limited _____

Additional health information _____

Licensed Physician's Signature _____	Name Printed _____
Address _____ <small>Street and Number</small>	Phone _____ <small>City State Zip</small>
Date of form completion _____	*by _____ <small>*Initial if completed by nurse or physician's assistant</small>



2010 Medication Administration Form

For Summer Camp and Adventure Trips

**To be completed and signed by physician
To be verified and signed after completion by parent**

Camper Name _____ Birth date _____ Gender _____ Age _____
 Home address _____
 Diagnosis _____
 Name of Licensed Prescriber and Title (*please print*) _____
 Prescriber's Signature _____ Date _____
 Address or Stamp _____ Phone _____

The camper self-administers all medication under the supervision of the health lodge staff.

Name of Medication	Dosage	Frequency/Times	Prescriber's Initials	Parent's Initials

To be completed by parent/guardian
 I request that my child, _____, receive the medication(s) listed above while at Camp Chingachgook.
 Parent/guardian Signature _____ Date _____

Refusal of Medication Administration

I am the parent/guardian of _____. I understand that the following medication(s) appear on his/her health form: _____.

It is my desire that the above-listed medication(s) be held from administration during camp. I take full responsibility for this action, and do not hold Camp Chingachgook responsible for not administering of the medication(s).

Parent/guardian Signature _____ Date _____
 Staff Signature and Title _____ Date _____