



CHIPINAW STAFF MEDICAL FORM

Page 1 & 2 are to be filled out by *staff member*. Page 3 & 4 to be filled out by *physician* and returned to our office by May 15th.

Campus: Chipinaw Silver Lake

Name _____ Birthdate ____/____/____ Age at camp _____
Last First Gender: Male Female

Home Address _____
Street Address City State Zip

Mother's Name _____ Home Phone _____

Cell # _____ Work Phone _____ Email Address _____

Father's Name _____ Home Phone _____

Cell # _____ Work Phone _____ Email Address _____

Emergency Contact

Name _____ Relationship _____ Phone (____) _____ - _____

Name _____ Relationship _____ Phone (____) _____ - _____

Physician / Pediatrician _____ Phone (____) _____ - _____

Orthodontist _____ Phone (____) _____ - _____

Dentist _____ Phone (____) _____ - _____

Are you currently receiving any form of medical treatment or taking any medication? Yes No

If yes, Please explain _____

Name of physician treating for above _____ Phone (____) _____ - _____

Health History (Please check all that apply)	
<input type="checkbox"/> ADD / ADHD	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Ear Infections	<input type="checkbox"/> Headaches
<input type="checkbox"/> Glasses / Contact Lenses	<input type="checkbox"/> Nose Bleeds
<input type="checkbox"/> Heart Disease / Defect	<input type="checkbox"/> Chicken Pox
<input type="checkbox"/> Seizure Disorder	<input type="checkbox"/> Sleepwalking
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Bedwetting
<input type="checkbox"/> Asthma	<input type="checkbox"/> Eating Disorder
<input type="checkbox"/> Surgeries _____	
<input type="checkbox"/> Other _____	

Allergies (Please check all that apply)	
<input type="checkbox"/> Penicillin	<input type="checkbox"/> Animal Dander
<input type="checkbox"/> Sulfa	<input type="checkbox"/> Dairy
<input type="checkbox"/> Aspirin	<input type="checkbox"/> Insect Stings
<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Peanut / Nut _____
	<input type="checkbox"/> Food _____
<input type="checkbox"/> Other _____	
Describe Reaction: _____	
Requires Epi-Pen: <input type="checkbox"/> Yes <input type="checkbox"/> No	

Insurance Information

International Staff: Please attach all of your agency insurance paperwork.

American Staff: Fill out insurance information below.

Is the staff member covered by medical/hospital insurance? Yes No

If so, indicate carrier or plan name: _____ ID#: _____

Group #: _____ Prescription Plan #: _____

Name of insured: _____ Relationship to participant: _____

Social Security # and date of birth of family member who is named on insurance plan: _____ DOB: ____/____/____

Please include a photo copy of
Health Insurance card or
Agency ID card here

Please include a photo copy of
Prescription Medication card or
Travel Insurance card here

Staff Member's Authorization
Permission to Provide Necessary Treatment or Emergency Care

(MUST be completed before you can be admitted to camp)

I the undersigned, staff member _____, do hereby authorize Camp Chipinaw, or any authorized representative of the Camp to act as my agent(s). I hereby give permission to the medical personnel selected by Camp Chipinaw to:

Order X-rays, routine tests, and treatment

Duplicate and release any records to appropriate personnel for insurance and treatment purposes

Provide or arrange necessary related transportation

In the event I cannot be reached in an emergency, I hereby give permission to any licensed physician or surgeon selected by the camp director to secure and administer treatment, including hospitalization, for the person named above.

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 the 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 judgement may deem advisable.

I further give my permission for all pertinent health information to be duplicated and released to the appropriate personnel for treatment.

This authorization shall remain effective until August 30, 2009 unless sooner revoked in writing and delivered to said agent(s).

This health history is correct and complete as far as I know and the person herein described has permission to engage in all camp activities except as noted. This completed form may be photocopied for trips out of camp.

Staff Member's Signature _____ **Date** ____ / ____ / ____

Physician's Section (Pages 3 & 4 to be completed by a licensed physician.)

New York State law requires the following information to be provided prior to a staff member's admission to camp. This form needs to be filled out within 6 months of the start of camp. If there are any changes to medical history or medication, this information needs to be forwarded to the camp health center immediately.

PLEASE PRINT

Staff Member's Name _____ Age _____ Gender: Male Female
Last First

Date of examination ____ / ____ / ____

B/P ____ / ____ Weight _____ Height _____ Urine _____ Vision _____

Immunization Record:

DTaP						
Polio						
Pevnar						
HiB						
Hep B						
MMR						
Varicella						
Hep A						
Meningococcal						

***Need 4 Polio by 6 yrs old**

Allergies _____

Significant Medical History _____

Special Dietary Restrictions _____

Activity Restrictions (if any) _____

Current Medication

If staff member takes any **daily** or **as needed** medication, they must be listed, otherwise the medicine will not be given.

- This person takes NO medication on a routine basis.
- This person takes medication as follows:

Medication	Dosage	Times taken each day	Reason for Taking

Identify any medication taken during the school year that participant does/may not take during the summer:

New York State Law requires this section to be filled out by a physician in order for our nurse to dispense over the counter non-prescription medication to you when needed. **Yes or No must be circled for each drug.**

Standard Over the Counter / PRN Medications (meds available in the infirmary/first Aid Kit; to be administered at the discretion of an RN)

DRUGS	ROUTE	DOSAGE	SCHEDULE	PROVIDER ORDER	COMMENTS
Acetaminophen	PO (chewable tabs, elixir, or tabs)	Per label Instructions by, age / weight	q 4 hr prn pain or temp > 100.3	Yes / No	
Ibuprofen	PO (chewable tabs, elixir, or tabs)	Per label Instructions by, age / weight	q 6 hr prn pain or temp > 100.3	Yes / No	
Robitussin	PO (chewable tabs, elixir, or tabs)	Per label Instructions by, age / weight	q 4 hr prn cough	Yes / No	
Tums, Maalax, Children's Mylanta	PO (chewable tabs, elixir, or tabs)	Per label Instructions by, age / weight	BID - TID prn upset stomach	Yes / No	
Dramamine	PO (chewable tabs, elixir, or tabs)	Per label Instructions by, age / weight	q 6 - 8 hr prn motion sickness	Yes / No	
Dimetapp	PO (chewable tabs, elixir, or tabs)	Per label Instructions by, age / weight	q 4 - 6 hr prn nasal congestion, drainage	Yes / No	
Benadryl	PO (chewable tabs, elixir, or tabs)	Per label Instructions by, age / weight	q 6 hr prn allergic reaction (hives, insect bites)	Yes / No	
Hydrocortisone	Topical Cream	Per label Instructions by, age / weight	BID prn rash	Yes / No	
Triple Antibiotic	Ointment	Per label Instructions by, age / weight	BID prn minor bacterial infections	Yes / No	

Please Note: We provide the above "as needed" over the counter medications free of charge. Therefore there is no need for you to bring them to camp.

I have examined the patient herin described and have reviewed the health history. It is my opinion that this person is physically able to engage in the regular camp activities, except as noted.

Physician's Signature _____ Date _____

Please Print Name _____ Phone # _____



Please Return To:

Camp Chipinaw
85 Silver Lake Road
Swan Lake, New York 12783
845-583-5600