CAMP CHIPINAW MEDICAL FORM

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

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 (____) ______ - ______

Is your child 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)

- ❑ ADD / ADHD
- ❑ Ear Infections
- ❑ Glasses / Contact Lenses
- ❑ Heart Disease / Defect
- ❑ Seizure Disorder
- ❑ Diabetes
- ❑ Asthma
- ❑ Pneumonia
- ❑ Headaches
- ❑ Nose Bleeds
- ❑ Chicken Pox
- ❑ Sleepwalking
- ❑ Bedwetting
- ❑ Eating Disorder
- ❑ Surgeries ______________________
- ❑ Other ______________________

Allergies (Please check all that apply)

- ❑ Penicillin
- ❑ Sulfa
- ❑ Aspirin
- ❑ Hay Fever
- ❑ Animal Dander
- ❑ Dairy
- ❑ Insect Stings
- ❑ Peanut / Nut __________
- ❑ Food ______________
- ❑ Other ______________________

Describe Reaction: ______________________

Requires Epi-Pen: ❑ Yes ❑ No

Insurance Information

Is the camper covered by family medical/hospital insurance? ❑ Yes ❑ No

If so, indicate carrier or plan name: ______________________ ID#: ______________

Group #: ______________________ Prescription Plan #: ______________

Name of insured: ______________________ Relationship to camper: ______________

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 here

Please include a photo copy of
Prescription Medication Card here

Parents Authorization
Permission to Provide Necessary Treatment or Emergency Care

(MUST be completed before your child can be admitted to camp)

I/We, the custodial parent(s) of ____ , a minor, do hereby authorize Camp Chipinaw, or any authorized representative of the Camp to act as my/our 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 for my child

In the event I/we 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/we 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 16, 2010 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.

Parent(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 camper'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

Camper's Name__________________________________ Age ______ Gender: ❑ Male ❑ Female
Last First

Date of examination ______/______/______ *(Must be within a year of the first day of camp)*

B/P _____/_______ Weight ____________ Height ____________ Urine ____________ Vision ____________

Immunization Record:

DTaP						
Polio						
Prevnar						
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 (All daily medication prescriptions must be sent to CampMeds Inc. for proper packaging. Not complying with this policy will incure a $100 handling fee.)

If camper 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

❑ This person takes growth hormone treatments.

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 your child 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	

Parents: Please note, we provide the above "as needed" over the counter medications free of charge. Therefore there is no need for you to send them through CampMeds or with your camper.

I have examined the patient herin described and have reviewed the health history. It is my opinion that this child 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

CAMP CHIPINAW

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

Dear Parent:

I am writing to inform you about meningococcal disease, a potentially fatal bacterial infection commonly referred to as meningitis, and a new law in New York State. On July 22, 2003, the New York State Public Health Law (NYS PHL) was amended to include §2167 requiring overnight children's camps to distribute information about meningococcal disease and vaccination to the parents or guardians of all campers who attend camp for 7 or more nights. This law became effective on August 15, 2003.

Camp Chipinaw is required to maintain a record of the following for each camper:

- A response to receipt of meningococcal meningitis disease and vaccine information signed by the camper's parent or guardian; AND
- Information on the availability and cost of meningococcal meningitis vaccine (Menomune™); AND EITHER
- A record of meningococcal meningitis immunization within the past 10 years; OR
- An acknowledgement of meningococcal meningitis disease risks and refusal of meningococcal meningitis immunization signed by the camper's parent or guardian.

Meningitis is rare. However, when it strikes, its flu-like symptoms make diagnosis difficult. If not treated early, meningitis can lead to swelling of the fluid surrounding the brain and spinal column as well as severe and permanent disabilities, such as hearing loss, brain damage, seizures, limb amputation and even death.

Cases of meningitis among teens and young adults 15 to 24 years of age have more than doubled since 1991. The disease strikes about 3,000 Americans each year and claims about 300 lives.

A vaccine is available that protects against four types of the bacteria that cause meningitis in the United States - types A, C, Y and W-135. These types account for nearly two thirds of meningitis cases among teens and young adults.

Information about the availability and cost of the vaccine can be obtained from your health care provider and by visiting the manufacturer's website at www.meningitisvaccine.com.

Please complete the Meningococcal Vaccination Response Form and return it to our winter address with the rest of the forms that need to be returned.

To learn more about meningitis and the vaccine, please consult your child's physician. You can also find information about the disease at the New York State Department of Health website: www.health.state.ny.us, and the website of the Center for Disease Control and Prevention (CDC): www.cdc.gov/ncidod/dbmd/diseaseinfo.

Sincerely,

MENINGOCOCCAL MENINGITIS VACCINATION RESPONSE FORM

New York State Public Health Law requires the operator of an overnight children's camp to maintain a completed response form for every camper who attends camp for seven (7) or more nights.

Check one box and sign below.

❑ My child has had the meningococcal meningitis immunization (Menomune™) within the past 10 years. Date received: ___________________

[Note: The vaccine's protection lasts for approximately 3 to 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 disease.

Signed: ___________________________________ Date: ___________________
(Parent / Guardian)

Camper's Name: ________________________________ Date of Birth: _______________

Mailing Address: ____

Parent/Guardian's E-mail address (optional): ____

Phone-954-577-0025 CampMeds **Fax-954-475-3055**

Pre-packaged Medications for Campers

Dear Camp Parents,
This summer Camp Chipinaw will continue work with ***CampMeds, Inc***, a pre-packaged medication program to dispense and package your child's medication for camp. Camp families are **required** to register with ***CampMeds*** if your child takes medicine while at camp. The ***CampMeds*** pharmacy will dispense all of your child's prescription and non-prescription medicine taken daily or as needed. This includes vitamins. All pills will be dispensed and individually packaged in sealed packets labeled with your child's name, medicine, dosage, date and time to be given. Medication not in pill form (liquids, inhalers, drops, etc), will be dispensed as well. Our system ensures that each camper receives their correct medicine at the correct time. All medicine will be shipped to camp prior to your child's arrival.

What you need to do:

1. Register on www.CampMeds.com (you may register prior to obtaining prescriptions)
2. Note the Camper ID # you will receive when registered. Print out receipt at the end registration.
3. Obtain original prescriptions written for 30 day increments**.** (Refer to FAQ #11)
4. Write Camper ID # on top corner of prescriptions. *Do not send us medication, only written prescriptions.
5. Prescriptions are filled as written. It is your responsibility to confirm all prescriptions are written correctly; exactly how and when your child takes the medication (daily or PRN), that the correct med is prescribed and the dosing is correct. (Refer to FAQ #2 and #15)**.**
6. Prescriptions written for daily use must have a refill. Unused meds are sent home from camp
7. **For Controlled Substances:** law requires a new prescription to be written for each 30 day supply. Two separate 30 day Rx's are required for Controlled Substances. No refills and only 30 days worth of meds should be written on the prescription. Send all prescriptions together
8. Non-prescription meds/vitamins: physician's authorization or written directions by parent is required.
9. Include a copy of both sides of your insurance/prescription card.
10. Mail prescriptions, registration receipt and copy of insurance card directly to:
    CampMeds PO Box 267037, Ft. Lauderdale, FL 33326-7037

Fees: There is a one-time registration fee of $60.00 for the entire summer which will be charged to your credit card immediately upon registration. This fee includes packaging, shipping and refills.
Fees are per camper, not prescription, and do not include the cost of medicine.
NON-PILL MEDS **-** For campers taking meds such as liquids, eye/ear drops, inhalers etc; a one- time fee of $30 per camper will be charged instead of the above packaging fee.

Deadlines: **ALL OF THE ABOVE ITEMS MUST BE BY MAY 27TH.**
A $25 late fee will be charged to your credit card if any of the items above are received after deadlines.

Please be aware that your credit card will be charged the shipping cost for any med change or if additional meds are ordered and sent to camp after your initial medication and/or refills have been sent.

Email Notification: You are notified by email when ***CampMeds*** receives your online registration, when your prescriptions are received and when meds are sent to camp. Contact us if you do not receive a confirming email within one week of sending prescriptions.

Insurance/Prescription Meds: The ***CampMed's*** licensed pharmacy partner accepts most insurance plans. They will verify your insurance upon registration and submit to your plan once camp begins. You are responsible for all co-payments, deductibles and meds not covered by your insurance. **All of your med charges will appear on your credit card statement from the Pharmacy usually *after your child returns home*. You are responsible to notify ***CampMeds*** of any changes to your credit card and/or insurance plan. If the pharmacy is not a provider for your plan, you will be notified and given the option to contact camp for alternative arrangements.

OTC Items and Meds Not Covered by Insurance*:* Will be charged to your credit card by the Pharmacy.

Please refer to our website www.CampMeds.com for registration and important details. For questions contact ***CampMeds*** at 954-577-0025 or info@CampMeds.com*.* **Please review the following FAQ's.**