Hillside Summer Camp
Green Chimneys 400 Doansburg Road, Brewster, NY 10509
Phone #: 845-279-2995 Fax: 845-279-3077

REQUIRED MEDICAL HISTORY

(Parent or Legal Guardian to Complete)

Please Check One: ( ) Returning Camper ( ) New Camper ( ) Returning Staff ( ) New Staff

Session: _____

Camper Name _____ **Date of Birth** _____
Address _____ **Phone#:** _____
_____

Emergency Notification:

With whom does child reside and what is / are his / her relationship(s) with the child?_____
Parent 1 Name_____ Phone: Home _____ Work _____ Cell _____
Parent 2 Name_____ Phone: Home _____ Work _____ Cell _____

Person to contact in an emergency if parents are unavailable:
Name:_____ Phone: Home_____ Work_____ Cell _____
Physician:_____ Phone_____
Dentist/Orthodontist:_____ Phone_____

Emergency Medical Information (check yes or no)

Yes___ No___ Allergy to a medicine, food, plant, animal, or insect
Yes___ No___ Do you have an epinephrine pen?
Yes___ No___ Any condition that requires special care, medication or diet
Yes___ No___ Asthma
Yes___ No___ Contact Lenses
Yes___ No___ Seizure Disorder
Yes___ No___ Diabetes
Yes___ No___ Heart Trouble
Yes___ No___ Bleeding Disorder
Yes___ No___ Dentures
Yes___ No___ Bonded Teeth

Explain any of the above:_____
_____

Medical History (check yes or no)

	Yes	No	Date	Details
Serious illness	_____	_____	_____	_____
Serious injury	_____	_____	_____	_____

Does your child have frequent: (circle yes or no)

Y / N Eye Infections **Y / N** Respiratory Infections
Y / N Ear Infections **Y / N** Urinary Tract Infections
Y / N Throat Infections **Y / N** Vaginal Infections

Does your child have: (circle yes or no)

Y / N Heart Murmur **Y / N** Menstrual Problems
Y / N Rheumatic Fever **Y / N** Hernia
Y / N Stomach/Intestinal Problems **Y / N** Back or Joint Pains

Explain any of the above:_____
Has this person had Chicken Pox? ( ) Yes ( ) No If yes, when? Date_____
Has this person had Mumps? ( ) Yes ( ) No If yes, when? Date _____
Has this person been exposed to a contagious disease within the past three weeks? _____
Has this person had lice in the past six months? _____
If applicable, has this person started menstruation? ( ) Yes ( ) No Has she been told about menstruation? ( ) Yes ( ) No
Does this person take <u>any</u> medication on a regular basis? Yes _____ No _____
Explain:_____

To the best of my knowledge, the above information is correct. I give my child permission to participate in all camp activities and trips.
In the event of accident or illness, I authorize the Camp to institute and obtain medical care.
**** In the event of a communicable disease outbreak, I understand this person will be excluded from camp if not fully immunized.**

DATE_____ **SIGNATURE (parent or legal guardian)**_____

MEDICAL EVALUATION

(To be completed by physician)

Name_____Date of Birth_____ has had a complete history and physical exam on_____
Month/Day/Year Month/Day/Year

Screening / Test Results

Height:	**BMI:**	**Vision/Type of Screening**
Weight:	□ Normal	With Glasses R 20 / L 20 /
Blood Pressure:	□ Abnormal	With out Glasses R 20 / L 20 /
Pulse:	Min:	
HCT/Hgb:	Slight:	**Auditory /Type of Screening**
Urinalysis:	Mod:	Right Pass / Fail
Gross Dental:	Marked:	Left Pass / Fail
Lead (Date/Result):	□ Referral to:	

TB: In high-risk group? □ yes □ no		
TB & other Test Results: (Sickle Cell, etc.)		
Test	**Date**	**Result**

Disease Assessment

Yes	No			Date of Onset
□	□	Asthma	□ Mild □ Moderate □ Severe □ Exercise Induced □ Unclassified	
□	□	Diabetes	□ Type I □ Type II	
□	□	Anaphylactic Reaction	□ Food □ Insect □ Latex □ Other: Explain	
□	□	Seizure Disorder	Type:	
□	□	Chicken Pox	If yes, when?	
□	□	Mumps	If yes, when?	
□	□	Other: Please Specify		

Immunization History

(Please provide month, day and year of immunization) – If your child has a religious or medical exemption from immunizations documentation is required

Vaccine	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DPT / Hib						
DTaP						
DT / Td						
OPV						
IPV						
MMR						
HiB						
Hep B						
Hep A						
Varicella						
TDap						
PCV						
HPV						
MCV						
Influenza						

Prescription Medication: Please complete with patient's current regimen for both scheduled and PRN medications including heparin flushes for central lines; please use additional paper if needed.

DRUG **ROUTE** **DOSAGE** **FREQUENCY** **COMMENTS**

_____

_____

_____

_____

Name_____ Date of Birth_____

Over the Counter Medication

The following medications will be provided by Green Chimneys Children's Health Services health center. These medications have been approved for use by the child's physician and requested by the parent.

Drug Name	Route	Dosage and schedule	Indications	Comments
Tylenol (or generic acetaminophen)	PO (chewable, elixir, or tabs)	Per label instructions by age/weight	Pain or fever (temp > 101 F)	Contact parent/guardian in the event of a fever
Ibuprofen	PO (chewable tabs, suspension or tabs)	Per label instructions by age/weight	Pain or fever (temp > 102 F)	Contact parent/guardian in the event of a fever
Benadryl (or generic)	PO (elixir, chewable tabs, or pills)	Per label instructions by age/weight	Allergic reactions (hives, insect bite)	Contact parent/guardian in the event of allergic reaction
Antibiotic ointment	Topical	Per label instructions by age/weight	Superficial cuts/abrasions	Check allergy history
Hydrocortisone Cream	Topical	Per label instructions by age/weight	Allergic reactions (contact dermatitis, insect bites)	
Calamine Lotion	Topical	Per label instructions by age/weight	Allergic reactions (hives, insect bites, poison ivy)	
Burn Gel	Topical	Per label instructions	Apply to minor burns	

Additional Orders: As deemed necessary by health care provider to be implemented by an RN:

_____

_____

_____

Physicians Signature: _____
Date: _____

Physicians Stamp: (required):

Guardian Signature: _____
Date: _____

Please indicate if your child has one of these conditions:

Type 1 diabetes _____ **Severe food allergy that requires epi pen or Benadryl ____**
Type 2 diabetes _____ **insect allergies that requires epi- pen or Benadryl _____**
Asthma_____

If any of the above are checked please include your childs management plan with this form. If needed a management plan can be downloaded from our website:

Limitations on Activities: **S**wimming_____Diving_____Hiking_____Athletics_____Other:_____

Explain above:_____

HIPPA Privacy Statement: Permission to Release Confidential Health Information

I give _____permission to release confidential health information to
Name of Medical Practice

_____ regarding this person_____
Name of Camp Name of Camper or staff member

Date:_____ Parents/Guardian Signature:_____

I certify that I have on this date examined the above named camper and that on the basis of my examination and the medical history as furnished to me, I have found no reason which would make it medically inadvisable for this camper to participate in physically strenuous activities.

Signature of Physican_____Date of Examination_____

Please Print: Physician's Name_____License# _____

Address_____ Phone#_____

Parents Signature: _____Date: _____