Clearpool Summer Camp
Green Chimneys at 33 Clearpool Road, Carmel, NY 10512
Phone #: 845-225-8226 Fax: 845-225-6337

REQUIRED MEDICAL HISTORY

(Parent or Legal Guardian to Complete)

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

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

Does your child have: (circle yes or no)

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

Explain any of the above: ____________

Has this person had Covid-19___? ( ) Yes ( ) No If yes, when? Date____________
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 and the submitted doctor's physical **(within 12 months of camp)** is up to date. There are no changes or updates to my child's health from submitted forms or ability to safely participate in camp activities. Any changes in my child's medical history will be submitted prior to camp.

I give my child permission to participate in all activities. In the event of accident or illness, I authorize the Green Chimneys 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						
HIV						
Hep B						
Hep A						
Varicella						
TDap						
PCV						
HPV						
MCV						
Influenza						
Covid 19						

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:

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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:

Swimming______________Diving______________Hiking_____________Athletics______________Other:________

Explain above:____

______________________ ____

HIPPA Privacy Statement: Permission to Release Confidential Health Information

I give (Name of Medical Practice)____permission to release confidential health information to (Name of Camp) ____ regarding this person (Name of Camper)_____________________________________ 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: _______________________________