CLEARPOOL SUMMER CAMP
33 Clearpool Rd, Carmel NY 10512
Phone #: (845) 225 8226 Fax: (845) 225 6337

green chimneys

REQUIRED MEDICAL HISTORY

(To be completed by Parent or Legal Guardian)

Camper Name:	**Date of Birth**	
Address (Street, Town and ZIP code)		
Parent/Guardian Name:	**Home Phone:**	**Cell Phone**

Emergency Contacts:

Person/s to contact in an emergency if parents are unavailable:

Name:	**Relationship:**	**Contact number:**
Name:	**Relationship:**	**Contact number:**

Emergency Medical Information: (check yes or no)

Yes ____ No ____ Allergy to medicine, food, plant, animal, or insect*
Yes ____ No ____ Camper requires epinephrine pen*
Yes ____ No ____ Condition that requires special care, medication or diet
Yes ____ No ____ Asthma*
Yes ____ No ____ Seizure Disorder
Yes ____ No ____ Diabetes*

Yes ____ No ____ Cardiac problems
Yes ____ No ____ Bleeding disorder
Yes ____ No ____ Wears contact lenses
Yes ____ No ____ Dentures
Yes ____ No ____ Bonded teeth

Explain any of the above _____
_____

*Please complete additional action plan for food/insect allergies, asthma and diabetes management.

Medical History: (check yes or no)

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

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** Back or Joint Pain
Y / N Stomach/Intestinal Problems **Y / N** Hernia

Explain any of the above: _____
_____

Has this person had COVID-19? **Y / N** If yes, when (date) : _____
Has this person had Chicken Pox? **Y / N** If yes, when (date) : _____
Has this person had Mumps? **Y / N** If yes, when (date) : _____

If applicable, has this person started menstruation? **Y / N** Have they been told about menstruation? **Y / N**

Does this person take any medication on a regular basis? **Y / N** If yes, please explain _____
_____

*Please note additional paperwork is required for medications to be administered while in camp program

To the best of my knowledge, the above information is correct and the submitted doctor's physical **(dated June 1, 2023 or after)** is up to date. There are no changes or updates to my child's health from the submitted forms, and they have the 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.

SIGNATURE (parent or legal guardian) _____ **DATE:** _____

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MEDICAL EVALUATION

(To be completed by physician)

Camper Name: _____ Date of Birth: _____ Date of Exam: _____

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						

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AUTHORIZATION FOR MEDICATION ADMINISTRATION

Required for every camper. Must include parent signature AND physician's signature and stamp

Camper 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. Check all that apply:

☐ **YES** ☐ **NO**
TYLENOL / ACETAMINOPHEN
Route: PO (by mouth: chewable tabs, elixir or tablet)
Dosage: Per label instructions by age/ weight
Schedule: PRN q4h for pain or fever > 101 F

☐ **YES** ☐ **NO**
ADVIL / IBUPROFEN
Route: PO (by mouth: chewable tabs, elixir or tablet)
Dosage: Per label instructions by age/ weight
Schedule: PRN q6-8h for pain or fever > 102 F

☐ **YES** ☐ **NO**
BENADRYL / DIPHENHYDRAMINE
Route: PO (by mouth: chewable tabs, elixir or tablet)
Dosage: Per label instructions by age/ weight
Schedule: PRN as per label instructions

TOPICALS

The following are allowed to be applied to area PRN per label instructions. Check all that may be utilized on the camper, per label instructions:

☐ Aloe
☐ Antiseptic Pain Relief
☐ Calamine Lotion
☐ Bacitracin / Neosporin
☐ Saline Eye Rinse
☐ Hydrocortisone Cream
☐ Sting-Relief Gel
☐ Petroleum Jelly

Additional Comments: _____

PRESCRIPTION MEDICATIONS

Please select one of the following:

☐ NO PRESCRIBED MEDICATION(S) REQUIRED AT CAMP
☐ THE FOLLOWING PRESCRIBED MEDICATION(S) WILL BE REQUIRED WHILE AT CAMP

Medication 1:
Name: _____
Dosage: _____
Frequency: _____
Reason for Medication: _____
_____

Medication 2:
Name: _____
Dosage: _____
Frequency: _____
Reason for Medication: _____
_____

Medication 3:
Name: _____
Dosage: _____
Frequency: _____
Reason for Medication: _____
_____

The medication administration policy is consistent with NY State guidelines, accepted medical practice and children's safety. All prescribed medications must be in a PRESCRIPTION bottle with a pharmacist's label attached stating name of camper and dosage information on it. We also require a PHYSICIAN'S ORDER from the prescribing physician to accompany medications for administration.

I hereby grant permission for Green Chimneys Summer Camps to administer the over the counter and/or prescription medications listed above as prescribed by my child's physician. I release Green Chimneys Summer Camps from all liability arising from administration of these medications.

Parent's Signature: _____ Date: _____

Parent's Name (Print): _____

PHYSICIAN'S STATEMENT

I certify that I have examined the above-named camper and based on 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 provided at camp.

Physician's Signature: _____ Date: _____

Physician's Name (Print): _____

PHYSICIAN'S STAMP HERE:

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ADDITIONAL MEDICAL INFORMATION

To be completed by parent

Camper Name: _____ Date of Birth: _____

HIPPA Privacy Statement: Permission to Release Confidential Health Information

(this section is optional and it allows for Green Chimneys Summer Camps to contact your physician's office in case of a medical emergency if you cannot be reached)

I give (Name of Medical Practice)_____permission to release confidential health information to (Name of Camp) _____ regarding this person (Name of Camper)_____ .

Parents/Guardian Signature:_____ Date:_____

INSTRUCTIONS TO COMPLETE MEDICAL FORMS:

Medical forms must be submitted to the camp office by May 1, 2024 to be reviewed by camp medical staff. No forms can be accepted on the first day of camp. If there are no forms on file for your child/ren, they will not be able to attend camp.

1. **Required Medical History** – parent/guardian to fill out and sign
2. **Medical Evaluation Form** – requires a physician office to complete
3. **Authorization for Medication Administration** - requires a physician to complete and sign AND parent/ guardian signature
4. **Additional Medical Information** - parent/guardian to complete and sign

Please note that additional action plans need to be completed for food/insect allergies, asthma, and diabetes management. The forms need to be completed and signed by a physician prior to submitting.

- **Food & Insect Allergy Action Plan**
- **Asthma Action Plan**
- **Diabetes Medical Management**

HOW TO SUBMIT COMPLETED MEDICAL FORMS:

Please make a copy of all the records prior to submission to the camp office

1. **Mail** in copies of medical forms to 33 Clearpool Rd, Carmel NY 10512
2. Submit forms via **fax**: (845) 225 6337
3. **Scan** (please do not take photo) forms to **upload** in the form section on your CampBrain account for each camper.