HILLSIDE SUMMER CAMP
400 Doansburg Rd, Brewster NY 10509
Phone #: (845) 279 2995 Fax: 845.225.1202

green chimneys

INSTRUCTIONS TO COMPLETE MEDICAL FORMS:

Medical forms must be submitted to the camp office by **May 15, 2027** to be reviewed by camp medical staff. No forms can be accepted on the first day of camp. If these forms are not on file for your child/ren, they will not be able to attend camp.

1. **Medical Evaluation Form** – requires a physician office to complete. Also indicate if additional action plan for medical conditions will be submitted prior to camper starting at camp.
2. **Authorization for Medication Administration** - requires a physician to complete, sign and stamp the required physician's statement AND parent/guardian signature
3. **HIPPA Privacy Statement (optional)**- parent/guardian to complete and sign.

Please note: Additional action plans need to be completed for food/insect allergies, asthma, seizure disorder 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
- Seizure Action Plan
- Any other medical condition that requires a plan of care

HOW TO SUBMIT COMPLETED MEDICAL FORMS:

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

1. **E-mail** scanned copies to campmedforms@greenchimneys.us
2. **Drop off** medical forms in person at 33 Clearpool Rd, Carmel NY 10512
3. Submit forms via **fax**: 845-225-1202
4. **Scan** (please do not take photo) forms to **upload** in the forms section on your CampBrain account for each camper.

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MEDICAL EVALUATION

Please note: Physical must be dated June 1st, 2026 or after to be accepted for Summer 2027

(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 attach full immunization history to this form

Medical Action Plans

Please indicate if this child has any of the following conditions:

- ☐ Asthma
- ☐ Diabetes
- ☐ Seizure Disorder
- ☐ Severe food allergy that requires epi pen or Benadryl
- ☐ Insect allergies that requires epi pen or Benadryl
- ☐ Any other medical condition that requires a plan of care

Please note: If any of the above are checked please ensure that the child's action plan(s) are included with this form.

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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
> _____

☐ **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
> _____

☐ **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
☐ Petroleum Jelly
☐ Hydrocortisone Cream
☐ Sting-Relief Gel

PRESCRIPTION MEDICATION ORDER

(To be completed by physician)

☐ 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 PRESCRIPTION from the prescribing physician to accompany medications for administration.

I hereby grant permission for Green Chimneys Summer Camps nurse to administer the over the counter and/or prescription medications acknowledged 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): _____

REQUIRED PHYSICIAN'S STATEMENT

I certify that I have examined the above-named camper and based on my examination and the medical history as provided to me, I have found no reason which would make it medically inadvisable for this camper to participate in all activities provided at camp. I also authorize the administration of the prescription medications indicated above.

Physician's Signature: _____ Date: _____

Physician's Name (Print): _____

PHYSICIAN'S STAMP HERE:

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HIPPA PRIVACY STATEMENT (optional)

To be completed by parent

Camper Name: _____ Date of Birth: _____

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 Green Chimneys Summer Camps regarding this person (Name of Camper)_____ .

Parents/Guardian Signature:_____ Date:_____