



# 2012 JCC of Mid-Westchester Camps Staff Medical Form

Return to Camp Office by June 1, 2012



Name \_\_\_\_\_ Birth date \_\_\_\_\_ Age at camp \_\_\_\_\_  
Last First Middle

Home address \_\_\_\_\_  
Street Address City State Zip

Custodial parent/guardian \_\_\_\_\_ Phone \_\_\_\_\_

Home address \_\_\_\_\_  
(if different from above) Street Address City State Zip

Business address \_\_\_\_\_ Phone \_\_\_\_\_  
Street Address City State Zip

Second parent or guardian or emergency contact \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Business address \_\_\_\_\_ Phone \_\_\_\_\_

If not available in an emergency, notify:

Name \_\_\_\_\_

Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_  
Street address City State Zip

**Insurance Information**

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

If so, indicate carrier or plan name \_\_\_\_\_ Group # \_\_\_\_\_

Carrier address \_\_\_\_\_

Name of insured \_\_\_\_\_ Relationship to participant \_\_\_\_\_

Social security number of policy holder or insurance ID number \_\_\_\_\_

**Parent/Guardian Authorizations:** This health history is correct and complete as far as I know. The person herein described has permission to engage in all camp activities except as noted. I hereby give permission to the camp to provide routine health care, administer prescribed medications and seek emergency medical treatment including ordering x-rays or routine tests. I agree to release any records necessary for insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for the person named above.

Signature of parent /guardian \_\_\_\_\_ Date \_\_\_\_\_

# Health History

The following must be filled in by the parent/guardian. The intent of this information is to provide camp health care personnel the background to provide appropriate care. Keep a copy of the completed form for your records. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp. Provide complete information so that the camp may be aware of your needs.

**Allergies** List all known.

Describe reaction and management of reaction.

**Medication allergies** (list)

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**Food allergies** (list)

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**Other allergies** (list) – include insect stings, hay fever, asthma, animal dander, etc.

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## Medications Being Taken

Please list all medications (including over-the-counter or nonprescription drugs) taken routinely. Keep the medication that you are bringing to camp in its original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage and the frequency of administration (**for Staff under the age of 18 years old**).

This person takes NO medications on a routine basis.

This person takes medications as follows:

Med #1 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_

Reason for taking \_\_\_\_\_

Med #2 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_

Reason for taking \_\_\_\_\_

Med #3 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_

Reason for taking \_\_\_\_\_

Attach any additional pages for more medications.

Identify any medications taken during the school year that participant does/may not take during the summer:

\_\_\_\_\_

### Restrictions

Explain any dietary restrictions.

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Explain any restrictions to activities (e.g. what cannot be done, what adaptations or limitations are necessary)

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# General Questions

Has/does the participant	Yes	No		Yes	No
1. Had any recent injury, illness or infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>	13. Ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have a chronic or recurring illness/condition?	<input type="checkbox"/>	<input type="checkbox"/>	14. Ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
3. Ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	15. Ever been diagnosed with a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	16. Ever had back problems?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>	17. Ever had problems with joints (e.g., knees, ankles)?	<input type="checkbox"/>	<input type="checkbox"/>
6. Ever had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>	18. Have an orthodontic appliance being brought to camp?	<input type="checkbox"/>	<input type="checkbox"/>
7. Ever been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	19. Have any skin problems (e.g. itching, rash)?	<input type="checkbox"/>	<input type="checkbox"/>
8. Wear glasses, contacts or protective eye wear?	<input type="checkbox"/>	<input type="checkbox"/>	20. Have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
9. Ever had frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>	21. Have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
10. Ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	22. Had mononucleosis in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
11. Ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	23. Had problems with diarrhea/constipation?	<input type="checkbox"/>	<input type="checkbox"/>
12. Ever had seizures?	<input type="checkbox"/>	<input type="checkbox"/>	24. Ever had emotional difficulties for which professional help was sought?	<input type="checkbox"/>	<input type="checkbox"/>

Please explain any "yes" answers, noting the number of the question you are referring to.

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Which of the following has the participant had?	Please give all dates of immunization for:							
	Vaccine:	Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
<input type="checkbox"/> Measles	DTP		_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Chicken Pox	TD (tetanus/diphtheria)		_____	_____	_____	_____	_____	_____
<input type="checkbox"/> German measles	Tetanus		_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Mumps	Polio		_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Hepatitis A	MMR		_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Hepatitis B	or Measles		_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Hepatitis C	or Mumps		_____	_____	_____	_____	_____	_____
	or Rubella		_____	_____	_____	_____	_____	_____
TB Mantoux Test	Haemophilus influenza B		_____	_____	_____	_____	_____	_____
Date of last test _____	Hepatitis B		_____	_____	_____	_____	_____	_____
Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative	Varicella (chicken pox)		_____	_____	_____	_____	_____	_____

Use this space to provide any additional information about the participant's behavior and physical, emotional or mental health about which the camp should be aware.

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Name of family physician \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Name of family dentist/orthodontist \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

# Health Care Recommendations by Licensed Medical Personnel

Date of Examination \_\_\_\_\_

Height	_____	Weight	_____	Lead level	_____
Eyes	_____	BP	_____	Scoliosis	_____
Glasses	_____	Heart	_____	Allergies	_____
Ears	_____	Lungs	_____	Teeth	_____
Abdomen	_____	General health	_____		

In my opinion, the above applicant  is  is not able to participate in an active camp program.

The applicant is under the care of a physician for the following conditions:

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## Recommendations and Restrictions at Camp

Medications to be administered at camp

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Any medically prescribed dietary restrictions

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Known allergies

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Description of any limitation or restriction on camp activities

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Additional information for health care staff at camp

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I have examined the child herein described and have reviewed his/her health history. It is my opinion that he/she is physically able to engage in all camp activities, except as noted.

_____		_____	
Examining physician's signature		Physician's printed name	
_____	_____	_____	_____
Street address	City	State	Zip
_____		_____	
Phone		Date completed	

**JCC of Mid-Westchester Camps 2012**  
**Medication Procedures**

Dear Parent/Guardian:

It is possible for you to have your child given both non-prescription and prescription medications, if needed. Please follow these guidelines.

**I. Acetaminophen (Tylenol) and Benadryl Only**

The medications that are available are acetaminophen (i.e. Tylenol, etc.) for fever or pain, and diphenhydramine hydrochloride (i.e. Benadryl, etc.) oral liquid for allergic reaction or itching. These medications will be given after you have been contacted in order to prevent medication duplication. In the unlikely event of a severe allergic reaction, Benadryl may be given with only your written permission. Even though we will call you before administering these medications, we are required to have it in writing in advance. If you wish to give permission for these medications, please complete the attached Non-Prescription Medication Permission Form and have your child's physician sign this form. Please return it to our office once you have both signatures but no later than June 20th.

**II. Prescription Medication(s) and Other Non-Prescription Medication(s)**

If your child has an illness that is being treated with either a prescription or a non-prescription medication the camp nurse or designee can administer it, if needed, during camp hours. In order to comply with Health Department regulations, please do the following if you need us to give medication to your child.

A. Contact the camp nurse to obtain necessary form and instructions.

B. Ask your physician for a written order for any medication, either prescription or non-prescription that your child needs to take during camp hours. In addition, ask the physician to write down any restrictions for your child while your child is taking the medication. Remember, if your child is placed on a medication, ask the physician when he puts the child on any medication, to write you a note for the school to dispense the medication, if your child needs it during the camp hours, which includes the dates and times for the medication to be given. Give the physician's note to the camp nurse with the medication.

C. In addition, you must sign an administration of medication form giving the camp nurse your permission to give your child the medication.

D. You must send the medication in the original container you received it in from the pharmacy or store. When you have a prescription filled, ask the pharmacist to put it into two containers - one for those doses to be given during the camp time and the other for those taken at home. On the container for prescription medications must be the child's name, medication name, dosage of medication, how the medication is to be given and frequency of administration. Containers saying administer as directed cannot be used by the camp nurse. On the containers of non-prescription medications, please write your child's name. All medications will be kept locked in the health office.

E. If possible, please bring the medication to the camp when it is the first time it is to be given. DO NOT SEND MEDICATION IN YOUR CHILD'S BAG. This is for the safety of all the children.

If you can't bring it please give it to the adult who is bringing your child to camp that day and ask them to bring the medication to the camp nurse.

The above guidelines are those required for the safe administration of medications to your child. It is in your child's best interest that you follow them. If you have any questions, please call 472-3300. Extensions for camps are below.

Yours truly,

\_\_\_\_\_  
Tobe Sevush x346  
Director, Summer Arts Center

\_\_\_\_\_  
Jayne Santoro x320  
Director, Dance Intensive

\_\_\_\_\_  
Caryn Symons X336  
Director, Gadol/Xtreme

Non-Prescription Medication Permission Slip (Under 18 years of age)

Please sign your name and have your child's physician sign for the medication(s) you want to have administered, if needed, to your child by the camp nurse or designee. In most instances, the medication will not be given to your child until after you have been called and given your verbal permission. However, in the case of an allergic reaction, the camp will make every effort to contact you, but will administer Benadryl if it is necessary as long as you and your child's physician have signed this form.

Child's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Weight: \_\_\_\_\_

Address: \_\_\_\_\_ Zip: \_\_\_\_\_

I give permission to the camp nurse or designee to administer the following medication(s), if needed, according to the dosage listed, to my child as named above:

1. Acetaminophen (I.E. Tylenol, etc.), dosage listed below, every 4-6 hours as needed for pain or fever:

Ages 12 and over (over 100 lbs.) 380-650 mg. PO

\_\_\_\_\_  
Parent's/Guardian's Signature

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Parent's/Guardian's Printed Name

\_\_\_\_\_  
Physician's Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician's Reg. #

2. Diphenhydramine Hydrochloride (Benadryl) 12.5-25 mg. PO for allergic reaction.

\_\_\_\_\_  
Parent's/Guardian's Signature

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Parent's/Guardian's Printed Name

\_\_\_\_\_  
Physician's Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician's Reg. #

**Topical Medications** that may be administered with parent/guardian **and** physician written permission to your child when at camp are listed below. Please note that written permission for use of these medications is an updated New York State policy as of 2011. We need both you, as your child's parent/guardian **and** your child's physician to sign for each topical medication.

**1. Bacitracin Ointment**

\_\_\_\_\_  
Parent's/Guardian's Signature

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Parent's/Guardian's Printed Name

\_\_\_\_\_  
Physician's Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician's Reg. #

**2. Hydrocortisone Cream 0.5%**

\_\_\_\_\_  
Parent's/Guardian's Signature

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Parent's/Guardian's Printed Name

\_\_\_\_\_  
Physician's Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician's Reg. #

**3. Calamine Lotion**

\_\_\_\_\_  
Parent's/Guardian's Signature

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Parent's/Guardian's Printed Name

\_\_\_\_\_  
Physician's Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician's Reg. #

Administration of Prescribed Medication (Under 18 years of age)

The camp has developed a policy regarding the administration of medications which is consistent with New York State guidelines, accepted medical practice and children's safety. Students are not to carry any medication for self-administration **MEDICATION MUST BE DELIVERED TO THE CAMP AND TAKEN HOME BY A PARENT OR GUARDIAN ONLY. THERE WILL BE NO EXCEPTIONS.**

Thank you for your cooperation.

TO BE COMPLETED BY THE PARENT/GUARDIAN:

I hereby request that the camp nurse (or Director's designee) administer medication as prescribed by my child's physician.

Student's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Parent/Guardian daytime telephone number \_\_\_\_\_

I hereby release the employees of the JCC of Mid-Westchester from any and all liability arising from the administration of this medication.

Date \_\_\_\_\_ Parent/Guardian Signature \_\_\_\_\_

Patient \_\_\_\_\_ Diagnosis \_\_\_\_\_

Medication \_\_\_\_\_ Dose \_\_\_\_\_ Frequency \_\_\_\_\_

Dates for Administration: From \_\_\_\_\_ Through \_\_\_\_\_

If PRN, signs and symptoms for administering medication \_\_\_\_\_

\_\_\_\_\_

Possible Side Effects \_\_\_\_\_

Restrictions(what and how long?) \_\_\_\_\_

M.D. Name (**PRINT**) \_\_\_\_\_ Tel. # \_\_\_\_\_

Address \_\_\_\_\_ Zip \_\_\_\_\_

N.Y.S. Reg. # \_\_\_\_\_

Date \_\_\_\_\_ M.D. Signature \_\_\_\_\_

**IMPORTANT:** Prescription medication must be in a **PRESCRIPTION BOTTLE** with a proper Pharmacist's label attached. Medication containers stating "give as directed" **CANNOT** be used by the JCC of Mid-Westchester. The label must list the student's name, medication, dosage, directions for use and the physician's name.