



CAMP SHANE

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Male Female

HEALTH EXAMINATION - STAFF

This page to be completed by you

Health record of: Last name First Date of birth

Home Address City State Zip Phone

MEDICATIONS:

Please check one: My child takes NO medications on a routine basis. My child takes medications as follows:

Med #1: Dosage: Time to be taken: Reason for taking:

Med #2: Dosage: Time to be taken: Reason for taking:

Attach additional sheets for more medications.

HISTORY:

Operations or serious injuries (include dates):

Chronic or recurring illness:

Tendency or susceptibility to:

Emotional or physical disabilities:

EMERGENCY CONTACT:

First Name Last Name Relationship

Address City State Zip

Home Phone Work Phone Cell Phone

Meningococcal Meningitis Vaccination: I have had the meningococcal meningitis immunization (Menomune™) within the past 10 years. (Physician should sign and date reverse side under "Immunization") Note: The vaccine's protection lasts for approximately 3 to 5 years. Revaccination may be considered within 3-5 years.

I have read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that my child will not obtain immunization against meningococcal meningitis disease.

Authorization of consent to treatment of a minor temporarily separated from his/her parents: "I hereby authorize Camp Shane, David Ettenberg, as our agent(s) to consent to any diagnostic procedure or medical care which is deemed advisable by, and is to be rendered under the general or special supervision of any licensed physician and surgeon at Catskill Regional Hospital of Sullivan County or any other Hospital, when such diagnosis or treatment is rendered at said hospital. Permission is granted to use our insurance to pay for services."

It is understood that this authorization is given in advance of any specific need for treatment to provide authority on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the physician in the exercise of his best judgment may deem advisable. As agent, Camp Shane is authorized to maintain patient information in our records for campers seen by the camp doctor.

Signature of Staff Member

Staff Member (Please print)

Date

PRINT STAFF MEMBER'S Last Name:

First Name:

Staff Member's Last Name: _____ First Name: _____

Medical History

This page to be completed by your physician

BP: _____ Weight: _____ Height: Ft. _____ In. _____

Date of last medical examination: ____/____/____. New York State Department of Health requires a physical within 12 months of camp attendance.

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

Current treatment at the time of this report includes: _____

Treatment to be continued at camp: _____

Has the participant had...	Mo/Year	Allergies	Yes	No	Immunization	Date
Chicken Pox.....	___/___	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Meningococcal.....	___/___/___
German Measles.....	___/___	Eczema	<input type="checkbox"/>	<input type="checkbox"/>	DPT.....	___/___/___
Measles.....	___/___	Hay Fever.....	<input type="checkbox"/>	<input type="checkbox"/>	TD (Tetanus/Diphtheria).....	___/___/___
Mumps.....	___/___	Poison Ivy, Etc....	<input type="checkbox"/>	<input type="checkbox"/>	Mumps.....	___/___/___
Hepatitis.....	___/___	Insect Sting.....	<input type="checkbox"/>	<input type="checkbox"/>	Polio.....	___/___/___
Epilepsy.....	___/___	Penicillin	<input type="checkbox"/>	<input type="checkbox"/>	Measles.....	___/___/___
Date of last TB Mantoux test.....	___/___	Other: _____			Rubella.....	___/___/___
Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative					Haemophilus Influenza B.....	___/___/___
Other: _____					Hepatitis B.....	___/___/___
					Varicella (Chicken Pox).....	___/___/___

Has/does the participant	Yes	No		Yes	No
1. Had any recent injury, illness or infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>	17. Ever had problems with joints (e.g., knees, ankles, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
2. Have a chronic or recurring illness/condition?	<input type="checkbox"/>	<input type="checkbox"/>	18. Have an orthodontic appliance being brought to camp?	<input type="checkbox"/>	<input type="checkbox"/>
3. Ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	19. Have any skin problems (e.g., itching, rash, acne)?	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	20. Have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>	21. Have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
6. Ever had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>	22. Had mononucleosis in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
7. Ever been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	23. Had problems with diarrhea/constipation?	<input type="checkbox"/>	<input type="checkbox"/>
8. Wear glasses, contacts or protective eye wear?	<input type="checkbox"/>	<input type="checkbox"/>	24. Have any problems with sleepwalking?	<input type="checkbox"/>	<input type="checkbox"/>
9. Ever had frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>	25. If female, have any abnormal menstrual history?	<input type="checkbox"/>	<input type="checkbox"/>
10. Ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	26. Have history of bed-wetting?	<input type="checkbox"/>	<input type="checkbox"/>
11. Ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	27. Have eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
12. Ever had seizures?	<input type="checkbox"/>	<input type="checkbox"/>	28. Ever had emotional difficulties for which professional help was sought?	<input type="checkbox"/>	<input type="checkbox"/>
13. Ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	29. Tendency of fainting?	<input type="checkbox"/>	<input type="checkbox"/>
14. Ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>			
15. Ever been diagnosed with a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>			
16. Ever had back problems?	<input type="checkbox"/>	<input type="checkbox"/>			

Please explain any "yes" answers, noting the number of the questions: _____

Staff Member's Last Name: _____ First Name: _____

Individual Standing Orders

This page to be completed by your physician

We are required by the New York State Department of Health to have standing orders for every person at camp. Approval by a physician allows camp nurses to administer over-the-counter medications at their discretion.

Below is a list of over-the-counter medications available at our Health Center.

If the camper cannot take the standard brand stocked by our Health Center, please specify substitution.

Drug Name	Route (please circle preferred formulation(s))	Dosage	Schedule and Indications	Camper's Physician Order	Comments/ Substitution
Tylenol	PO (elixir or tabs)	Per label instructions by age/weight	Q 4 hr prn for pain or fever > _____ F	Yes No	
Ibuprofen	PO (suspension, or tabs)	Per label instructions by age/weight	Q 6 hr prn for pain or fever > _____ F	Yes No	
Robitussin	PO (syrup)	Per label instructions by age/weight	Q 4 hr prn for cough	Yes No	
Pepto-Bismol	PO (liquid, or chewable tabs)	Per label instructions by age/weight	Q 30 mins to 1 hr prn for diarrhea (no>8 doses/24 hr)	Yes No	
Children's Mylanta	PO (chewable tabs)	Per label instructions by age/weight	BID-TID prn for stomach upset	Yes No	
Dramamine	PO (chewable tabs-50mg)	Per label instructions by age/weight	Q 6-8 hrs prn for motion sickness	Yes No	
Dimetapp	PO (elixir or tabs)	Per label instructions by age/weight	Q 6-8 hrs prn for nasal congestion/drainage	Yes No	
Benadryl	PO (elixir, chewable tabs or pills)	Per label instructions by age/weight	Q 6 hr prn for allergic reaction (hives, insect bite)	Yes No	
Sudafed	PO (tabs)	Per label instructions by age/weight	Q 6-8 hrs prn for nasal congestion/drainage	Yes No	
Hydrocortisone Cream	PO (ointment)	Per label instructions	Q 6 hr prn for skin irritations & rashes due to insect bites etc.	Yes No	
Other					

