The State of New York Board of Health requires that we have all necessary medical forms onsite prior to the start of camp. Any camper whose medical forms are not received by the registrar by July 24th, 2022 **WILL NOT** be able to participate in camp this year.

*ALL returning campers must fill out a NEW form each year with current information, date and signatures.*

\*The information on this form will be kept in strict confidence. It will be used only to meet the needs of your child or in an emergency.

**#1- Camper Information:**

|  |  |  |
| --- | --- | --- |
| Camper’s Name**:**  | Date of Birth**:**  | Date of Camper’s last Physical:  |
| Parent Name:  | Parent Phone Number:  |
| Emergency Contact Name: (if parent not reached)  | Emergency Contact Phone Number:  |
| Family Doctor Name: | Phone Number:   |

Does your child have any **activity** restrictions? [ ] Y [ ] N If so, please list:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child have any **dietary** restrictions (i.e. diabetic, lactose, gluten) [ ] Y [ ] N If so, please list:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child have any disabilities? (i.e. physical, emotional, learning). [ ] Y [ ] N If so, please list:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any accommodations or modifications to programming that can be offered to make your child comfortable during camp?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**#2-Permission to Treat Form**

**Please name any medications your child is currently taking and reason for the medication:** please make sure all medication is in its **original prescription bottle or over-the counter medication bottle**and properly labeled with medication and administration instructions.

1. Medication name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Tablet, capsule, liquid, intranasal spray, topical other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Time and frequency of administration (if daily) or if as needed (please specify):
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Diagnosis or reason for medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Medication name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Tablet, capsule, liquid, intranasal spray, topical other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Time and frequency of administration (if daily) or if as needed (please specify):
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Diagnosis or reason for medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Medication name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Tablet, capsule, liquid, intranasal spray, topical other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Time and frequency of administration (if daily) or if as needed (please specify):
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Diagnosis or reason for medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The following non-prescription medications may be stocked in the camp Health Center and are used on an **as needed basis** to manage illness and injury.

Check the box for any medications that the camper should ***NOT*** be given.

|  |  |
| --- | --- |
| [ ]  Acetaminophen (Tylenol 325-650mg pill form and liquid form)  | [ ]  Bismuth Subsalicylate (Pepto-Bismol 25cc)  |
| [ ]  Ibuprofen (Motrin 200-400mg)  | [ ]  Cough meds (r-Robitussin 30cc)  |
| [ ]  Antihistamine/allergy medicine (Benadryl 25-50mg, Loratidine 10mg)  | [ ]  Anti-Itch cream (1% Hydrocortisone)  |
| [ ]  Tums 500mg  | [ ]  Imodium 10mg  |
| [ ]  Vitamin C 500mg  | [ ]  Other:  |

**I grant permission and consent for the Camp Arevelk nurse to administer listed prescriptions and/or over-the-counter medications to my child during the week of August 14-20, 2022 at camp.** [ ]  **Y** [ ]  **N**

**Please list any allergies your child may have (dietary, environmental, medications)**

|  |  |  |
| --- | --- | --- |
| **Allergy** | **Reaction** | **Treatment** |
|  |  |  |
|  |  |  |

**#3- Health History:** Please check if the camper has suffered/is currently suffering from the following:

|  |  |  |  |
| --- | --- | --- | --- |
| [ ]  Ear Infections | [ ]  Frequent Colds | [ ]  Asthma | [ ]  Epilepsy/Seizures |
| [ ]  Nose Bleeds | [ ]  Insect Stings | [ ]  Upset Stomach  | [ ]  Altitude Sickness |
| [ ]  Headache/Migraines | [ ]  Sleep walking | [ ]  Diabetes | [ ]  Hay Fever |
| [ ]  Bleeding Disorder | [ ]  Hypertension | [ ]  Rheumatic Fever | [ ]  Painful Menstrual Cramps |
| [ ]  ADD/ADHD | [ ]  Thyroid | [ ]  Depression/Anxiety | [ ]  Bladder Problems |

 [ ]  Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**#4- Immunization History\***

Please scan and email a copy of the record of basic immunization and most recent booster doses.

\*You may attach a copy of your most recent immunization record from your doctor’s office.

|  |  |  |
| --- | --- | --- |
| Immunization | Date | Booster Date |
| Tetanus |  |  |
| Diphtheria |  |  |
| Pertussis |  |  |
| HPV (Human Papilloma) |  |  |
| Meningococcal |  |  |
| Polio (IPV) |  |  |
| Measles |  |  |
| Mumps |  |  |
| Rubella |  |  |
| Hepatitis A |  |  |
| Hepatitis B |  |  |
| Varicella (Chicken Pox) |  |  |
| Rotavirus (Rota) |  |  |
| Haemophilus Influenzae B (HiB) |  |  |
| PCV (Pneumococcal) |  |  |

**#5- Insurance Information:**

Do you carry any family medical/hospital insurance? [ ]  Y [ ]  N

* If you do, please scan and email a copy of the card or attach a copy of the card to these forms (includes OHIP)

**Is there anything else we should know about your child’s health?**

**­­­­­­­­­**

**Checklist: Did you complete the following items?**

[ ] Page 1: #1- Camper Information

[ ]  Page 2: #2- Permission to Treat Form

[ ]  Page 2: #3- Health History

[ ]  Page 3: #4- Immunization Record or copy of immunization record from doctor’s office

[ ]  Page 3: #5- Insurance Information and copy of insurance card

Signature of Parent/Guardian: ­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_

Please print, scan and email sent to CampArevelk@gmail.com

If necessary, printed forms can be sent to:

**Camp Arevelk**

**65 Kinnicutt Rd.**

**Worcestor, MA 01602**

For questions contact us at CampArevelk@gmail.com or at +1 (905)-597-5967 (CDN #)