CAMPER HEALTH EVALUATION FORM

CAMP CHERITH® of Western New York

Please bring this form and immunization records with you on the day you come to camp.
This form MUST have both physician's and parent's signature.

Camper's Name: _____ Birth date: _____ Age: _____
Address: _____ Phone: _____
Street and number City/Town State Zip
Custodial Parent/Guardian: _____ Home/Cell: _____
Parent Address (if not same as above) _____ Business Phone: _____
If not available, in an emergency please notify:
Name & Relationship: _____ Home phone: _____
Address: _____ Cell: _____
Street and number City/Town State Zip

PHYSICAL HEALTH HISTORY: To be filled out by a parent or legal guardian.

Allergies: ☐ No known allergies. ☐ This camper is allergic to: ☐ Food ☐ Medicine ☐ The environment (insect stings, hay fever, etc.) ☐ Other ***(Please describe below what the camper is allergic to and the reaction seen.)***

Diet, Nutrition: ☐ This camper eats a regular diet. ☐ This camper eats a regular vegetarian diet. ☐ This camper is lactose intolerant. ☐ This camper is gluten intolerant. ☐ Other, ***please explain in space.***

Restrictions: ☐ I have reviewed the program and activities of the camp and feel the camper can participate without restrictions. ☐ I have reviewed the program and activities of the camp and feel the camper should be exempt or can participate with the following restrictions or adaptations.
(Please describe below.)

Please state any chronic health concerns (Diabetes, strep throat, asthma, braces, etc.) or **recent health issues and recent injuries** (broken bones, sprains, bruises).

Mental, Emotional, and Social Health: *Check "Yes" or "No" for each statement.*

Has the camper:
1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)? ..... ☐ Yes ☐ No
2. Ever been treated for emotional or behavioral difficulties or an eating disorder?……..... ☐ Yes ☐ No
3. During the past 12 months, seen a professional to address mental/emotional health concerns?……..……..... ☐ Yes ☐ No
4. Had a significant life event that continues to affect the camper's life?..... ☐ Yes ☐ No
(History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)

Please explain "Yes" answers in the space below, noting the number of the questions. The camp may contact you for additional information.

☐ **IMMUNIZATION RECORDS:** Please attach *an up to date copy of physician's immunization record (*required by NYS law for each camper and must be updated annually). **A complete record shall include immunization dates** against diphtheria, haemophilus influenza type b, hepatitis b, measles, mumps, poliomyelitis, rubella, chicken pox, tetanus and meningitis.
☐ **Not Immunized (check here)** Must sign a waiver

☐ **MEDICAL EXAMINATION: To be completed by a Licensed Physician/Nurse Practitioner/PA**
After examination of the participant **it is my opinion that the participant _____ is _____ is not able to participate in an active camp program.**
The participant is under the care of a physician for the following conditions: (Please include any medications and describe any restrictions including any activities the participant should be exempt from.)

_____

_____

This examination should be performed within 12 months of arrival at camp.
Name of Physician and title _____ **Date of Examination** _____
Signature of Physician: _____ **Date:** _____
Address: _____ **Phone:** _____

CCWNY provides the following generic **over the counter medications and campers do not need to supply them**. Parent must indicate which medications may be administered while the child is at camp. Only medications marked "YES" and determined to be necessary will be administered at the discretion of the camp nurse. Medications will be dispensed "per label directions" unless otherwise specified.

Medication Name (or store brand/generic)	YES	NO	Comments (specific instructions for dosage)
Advil/Ibuprofen (for fever or pain)			
Benadryl/Diphenhydramine (for severe allergic reactions)			
Cough Drops (for throat irritation)			
Tylenol/Acetaminophen (for fever or pain)			
Calamine Lotion (for insect bites)			
Cortisone Cream (for skin irritation)			
First Aid Cream (for minor cuts/scratches)			
Insect/tick repellent			

MEDICATION INFORMATION: ALL medications including prescriptions, over the counter meds, herbal remedies, and dietary supplements must be stored at the health center (not with the camper!) and administered by the camp nurse. Self-carry emergency medications (inhalers, epi-pen) require prescription and prior approval from the camp nurse. Any camper found to be self-administering ANY medication could be grounds for dismissal from camp.

Below you must list all medications that will be brought to camp with this camper. This list MUST include all prescriptions, over the counter medications, herbal remedies, and dietary supplements. If medications must be taken on a time schedule, please include specific instructions with times indicated.

Name of Medication	Reason for taking	When Given	Amount of Dose given

- PRESCRIPTION DRUGS MUST BE IN ORGINAL CONTAINERS WITH PHARMACIST'S LABEL, CAMPER'S NAME AND THE DOCTOR'S INSTRUCTIONS.
- ANY OTHER MEDICATIONS/VITAMINS MUST BE IN ORIGINAL CONTAINERS AND LABELED WITH CAMPER'S NAME AND DIRECTIONS FOR USE.

☐ The health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities, except as noted by the medical provider and myself. I acknowledge residential camp experience may expose the camper to communicable diseases (meningitis, lice, etc.). I hereby authorize the camp personnel to handle any medical problem with my child during his or her stay at camp including contacting the family doctor for more information. In case of emergency, after every reasonable effort is made to contact the parent/guardian, permission hereby is given to the physician selected by the camp to provide proper treatment. Expenses incurred for medical needs of the camper are the responsibility of the parent.

☐ **PARENT AUTHORIZATION: This statement MUST be signed in order for camper to attend camp.**

Parent Signature: _____ **Date:** _____

Insurance Carrier: _____

Plan number/Group number: _____ **ID Number:** _____

Office use only: Arrival screening conducted by _____(Initials) time/ date_____
Any updates to health history form?.....No …….yes
Any signs symptoms of illness or injury?.....No……..yes
Any medications given to health center? ……..No …….yes
Any special needs of this person while at camp? ……No……..yes
**Any yes' note here_____

Exit note:
☐ Left camp with the following concern_____
_____
☐ Parent/guardian was notified
_____

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*Signature of RN on duty*_____ *Date*_____