

For Camp Use Only

# Camp Cedarbrook<sup>™</sup> in the Adirondacks

This information on this form is required for attendance at camp but is not part of the acceptance process. The information is gathered only to assist us in identifying appropriate care.  
**ANNUAL UPDATE REQUIRED.**

## 2010 Health History — FORM A

Must be completed by parents/guardians of minors attending or by adults attending.

Please complete the forms as follows. Keep a copy for your records.

- 1) Complete pages 1, 2, and 3 of FORM A (Health History) and the top of FORM B (Health-Care Recommendations/Examination). Attach additional pages as needed.
- 2) Give both forms to the participant's health-care provider for review and completion.
- 3) After both forms have been completed and signed by the parent/guardian (or adult participant) and health-care provider, mail forms to the Registrar before June 1.

Registrar address before June 15:  
11 Lake Shore Drive – 2D; Watervliet, NY 12189

Registrar address after June 15:  
59 Davignon Road; Corinth, NY 12822

Cabin or Tent

Name

### PARTICIPANT CONTACT INFORMATION — PLEASE PRINT

Participant is a:  Camper  Staff Member/Volunteer

Name of Participant \_\_\_\_\_ Gender:  Male  Female  
LAST FIRST MIDDLE

Address \_\_\_\_\_  
STREET ADDRESS CITY STATE ZIP

Birth Date \_\_\_\_\_ Age at camp \_\_\_\_\_ Participant's Social Security Number \_\_\_\_\_

#### Custodial Parent/Guardian

Name \_\_\_\_\_ Relationship to Camper \_\_\_\_\_ Phone \_\_\_\_\_

Home Address \_\_\_\_\_ Cellphone \_\_\_\_\_  
(If different from above) STREET ADDRESS CITY STATE ZIP

#### Second Parent or Guardian or Emergency Contact

Name \_\_\_\_\_ Relationship to Camper \_\_\_\_\_ Phone \_\_\_\_\_

Home Address \_\_\_\_\_ Cellphone \_\_\_\_\_  
(If different from above) STREET ADDRESS CITY STATE ZIP

### INSURANCE INFORMATION

The participant is covered by family medical/hospital insurance:  Yes  No

If so, indicate the carrier or plan name below:

Insurance Company \_\_\_\_\_

Policy/Group Number \_\_\_\_\_

Subscriber \_\_\_\_\_

**Attach photocopy of front of health insurance card here.**

**Attach photocopy of back of health insurance card here.**

### IMPORTANT — READ CAREFULLY. These signatures must be provided for attendance.

**MENINGOCOCCAL MENINGITIS VACCINATION:** I have read, or have had explained to me, the information supplied regarding meningococcal meningitis disease and vaccination. I understand that the vaccine's protection lasts for approximately 3–5 years and that revaccination may be considered within 3–5 years.

**MUST CHECK ONE BOX FOR ATTENDANCE.**

The participant has had the meningococcal meningitis immunization (Menomune<sup>™</sup>) within the past 10 years.

Date immunization received: \_\_\_\_\_

I understand the risks of not receiving the vaccine. I have decided that the participant will not obtain immunization against meningococcal meningitis disease.

**STANDARD OVER-THE-COUNTER/PRN MEDICATIONS** I hereby give permission for Camp Cedarbrook in the Adirondacks to administer the over-the-counter medications (namebrand or generic) as shown on FORM B, page 2, if the camp nurse deems it necessary. Dosages will be administered as physician directs.

**HEALTH AUTHORIZATIONS:** This health history is correct and accurately reflects the health status of the participant to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining health-care provider. I hereby give permission to the physician selected by Camp Cedarbrook in the Adirondacks to order x-rays, routine tests, and treatment related to the health of the participant for both routine health care and in emergency situations. If I cannot be reached in an emergency, I hereby give permission to the physician selected by Camp Cedarbrook in the Adirondacks to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for the participant. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form.

**IN ADDITION,** Camp Cedarbrook in the Adirondacks has permission to obtain a copy of the participant's health record from providers who treat the participant and these providers may talk with the camp's staff about the participant's health status. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to Camp Cedarbrook in the Adirondacks to arrange necessary related transportation for the participant.

SIGNATURE OF CUSTODIAL PARENT/GUARDIAN OR ADULT CAMPER/STAFFER \_\_\_\_\_ DATE \_\_\_\_\_

**PARTICIPANT AGREEMENT:** I understand and agree to abide by any restrictions placed on my participation in camp activities.

SIGNATURE OF MINOR OR ADULT CAMPER/STAFFER \_\_\_\_\_ DATE \_\_\_\_\_

*If for religious or other reasons you cannot sign this authorization, contact the registrar for a legal waiver which must be signed for attendance.*

**ALLERGIES**

- This participant has no known allergies.
- This participant is allergic to:
  - Food  Medicine  Environment (insect stings, hay fever, etc.)
  - Other

Please describe below all known allergies, reactions seen, and management of the reaction.

**RESTRICTIONS**

- I have reviewed the program and activities of the camp and feel the person can participate without restrictions.
- I have reviewed the program and activities of the camp and feel the person can participate with the following restrictions or adaptations. **Please describe below.**

**DIET, NUTRITION**

- This participant eats a regular diet.
- This participant eats a regular vegetarian diet.
- This participant has special food needs. **Please describe below.**

**IMMUNIZATION HISTORY**

Provide the month and year for each immunization. Immunizations must be current. Copies of immunization forms from health-care providers are acceptable; please attach to this form.

Immunization	Dose 1 Mo/Yr	Dose 2 Mo/Yr	Dose 3 Mo/Yr	Dose 4 Mo/Yr	Dose 5 Mo/Yr	Most Recent Mo/Yr
Diphtheria, tetanus, pertussis (DTaP), (TdaP), (dT), or (TdaP)						
Mumps, measles, rubella (MMR)						
Polio (PV)						
Haemophilus influenza B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox) <input type="checkbox"/> Had chicken pox Date:						
Meningococcal meningitis (MCV4)						
Tuberculosis (TB) Test	Date:		<input type="checkbox"/> Negative		<input type="checkbox"/> Positive	

**If the participant has not been fully immunized, sign the following:  
I understand and accept the risks to the participant from not being fully immunized.**

SIGNATURE OF CUSTODIAL PARENT/GUARDIAN OR ADULT CAMPER/STAFFER \_\_\_\_\_ DATE \_\_\_\_\_

**GENERAL HEALTH HISTORY** Circle Y for yes, N for no.

Has/does the participant:

1. Y N Ever been hospitalized?
2. Y N Ever had surgery?
3. Y N Have a chronic/recurring illness or condition?
4. Y N Had a recent infectious disease?
5. Y N Had a recent injury?
6. Y N Ever had a head injury/been knocked unconscious?
7. Y N Had asthma/wheezing/shortness of breath?
8. Y N Have diabetes?
9. Y N Ever had seizures?
10. Y N Have frequent headaches/ear infections?
11. Y N Wear eye glasses, contacts, or protective eyewear?
12. Y N Ever had fainting or dizziness?
13. Y N Ever fainted or had chest pain during or after exercise?
14. Y N Ever had high blood pressure/heart murmur?
15. Y N Had mononucleosis during the past 12 months?
16. Y N Have an abnormal menstrual history?
17. Y N Had problems with falling asleep/sleepwalking?
18. Y N Ever had back problems/joint problems?
19. Y N Have a history of bed-wetting?
20. Y N Had problems with diarrhea/constipation?
21. Y N Have any skin problems (itching, rash...)?
22. Y N Wear braces/bring an orthodontic appliance to camp?
23. Y N Traveled outside the country in the past nine months?

Please explain Y answers, noting the question's number. For travel outside the country, please name countries visited and dates of travel.

**MENTAL/EMOTIONAL HEALTH** Circle Y for yes, N for no.

Has the participant:

24. Y N Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (ADHD)?
25. Y N Ever been treated for emotional or behavioral difficulties or an eating disorder?
26. Y N During the past 12 months, seen a professional to address mental/emotional health concerns?
27. Y N Had a significant life event that continues to affect the participant's life? (Abuse, death of loved one, family change, adoption, foster care, new sibling, survived a disaster, etc.)

Please explain Y answers, noting the question's number. The camp may contact you for additional information.

**ADDITIONAL INFORMATION**

Please provide any additional information about the participant's health that you think important or that may affect the camper's ability to participate fully in the camp program. Attach additional pages as needed.

— FOR CAMP USE ONLY —  
**Entrance Examination**

Arrival  Entrance Exam Date \_\_\_\_\_ Other pertinent observations: \_\_\_\_\_

Weight \_\_\_\_\_ Temp \_\_\_\_\_

Hair  Clear  Other \_\_\_\_\_

Throat  Clear  Other \_\_\_\_\_

Feet  Clear  Other \_\_\_\_\_ Examiner: \_\_\_\_\_

1. **Y N** Any known exposure to communicable disease in past two weeks?

If yes, **what?** \_\_\_\_\_

**when?** \_\_\_\_\_

**Y N** Have you had it before?

**Y N** Have you been immunized against it?

2. **Y N** Any recent cold, sore throat, or ear infection with symptoms still present?

If yes, **symptoms:** \_\_\_\_\_

\_\_\_\_\_

**Y N** Finished antibiotics within last 48 hours?

If yes, **medication:** \_\_\_\_\_

\_\_\_\_\_

3. **Y N** Any open sores or cuts?

If yes, **where?** \_\_\_\_\_

\_\_\_\_\_

4. **Y N** Anything a doctor says you shouldn't do at camp?

If yes, **what?** \_\_\_\_\_

\_\_\_\_\_

Medications brought to camp: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Allergies: (write in red) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Treatments to be continued, special observations to be made at camp: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Name \_\_\_\_\_ Birth Date \_\_\_\_\_

**SECTION 1: Must be completed by parents/guardians of minors attending or by adults attending.**

**PARTICIPANT INFORMATION — PLEASE PRINT**

Name of Participant \_\_\_\_\_ Gender:  Male  Female Age at camp \_\_\_\_\_  
LAST FIRST MIDDLE

**Custodial Parent/Guardian**

Name \_\_\_\_\_ Phone \_\_\_\_\_

**Participant's Health-Care Providers**

Primary Doctor(s) \_\_\_\_\_ Phone \_\_\_\_\_

Dentist(s) \_\_\_\_\_ Phone \_\_\_\_\_

Orthodontist(s) \_\_\_\_\_ Phone \_\_\_\_\_

*PARENTS/GUARDIANS OR ADULT PARTICIPANTS: Stop here. Remaining sections of form to be completed by medical personnel.*

**SECTION 2: MEDICAL PERSONNEL. \*Must be completed by licensed physician/nurse practitioner/PA of participant.\***

Please review FORM A, pages 1, 2, and 3 and complete the remaining sections of this form, FORM B, pages 1 and 2. Attach additional pages as needed.

**HEALTH EXAMINATION BY A LICENSED PHYSICIAN/NURSE PRACTITIONER/PA**

Camp Cedarbrook in the Adirondacks requires a health exam within 12 months of camp attendance.

**Examination** I examined the participant on \_\_\_\_\_

Weight \_\_\_\_\_ Height \_\_\_\_\_

Blood Pressure \_\_\_\_\_

**Allergies**  This participant has no known allergies.

This participant is allergic to: *(please list next to each item)*

Food \_\_\_\_\_

Medicine \_\_\_\_\_

Environment (insect stings, hay fever, etc.) \_\_\_\_\_

Other \_\_\_\_\_

*Describe previous reactions:*

**Diet/Nutrition**  This participant eats a regular diet.

This participant has medically-prescribed meal plan or dietary restrictions:  
*(describe below)*

**Ongoing Treatment**  None

The participant is undergoing treatment at this time for the following conditions: *(describe below)*

Other treatments/therapies to be continued at camp:

None needed

**Medication**

No daily medications.

See individualized orders on the back of this page (FORM B, page 2) for participant's use of non-prescription and prescription medications.

**HEALTH-CARE PROVIDERS:**

*Complete FORM B, page 2, on the back of this page.*

**Limitations and Restrictions**  None

Description of any limitation or restriction on camp activities:  
*(describe below)*

**Additional Orders**  None

As deemed necessary by healthcare provider to be implemented by camp nurse—for example: peak flows, blood draws/lab work; dressing changes, cast care; feeds via GT; and so on.

**IMPORTANT—Medical Authorization**

I have reviewed the HEALTH HISTORY (FORM A), completed FORM B, and have discussed the camp program with the parent(s)/guardian(s) of the minor attending or with the adult attending. It is my opinion that the participant is physically and emotionally fit to participate in an active camp program (except as noted above).

\_\_\_\_\_  
SIGNATURE OF LICENSED PHYSICIAN/NURSE PRACTITIONER/PA

Print Name \_\_\_\_\_

Name \_\_\_\_\_ Birth Date \_\_\_\_\_

**SECTION 3: MEDICAL PERSONNEL. \*Must be completed by licensed physician/nurse practitioner/PA of participant.\***

**STANDARD OVER-THE-COUNTER/PRN MEDICATIONS—INDIVIDUALIZED ORDERS** 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 if approval is indicated below by the participant’s healthcare provider.

DRUG	ROUTE—Please circle preferred formulation(s)	DOSAGE	SCHEDULE AND INDICATIONS	CAMP HEALTHCARE PROVIDER ORDER Missing answer assumes “Yes”	COMMENTS
Acetaminophen (Tylenol)	PO (chewable tabs, elixir, or tabs)	Per label instructions by age/weight	Q 4 hr prn for pain or fever > _____-F	Yes No	
Ibuprofen (Advil, Motrin)	PO (chewable tabs, tabs, or suspension)	Per label instructions by age/weight	Q 6 hr prn for pain or fever > _____-F	Yes No	
Pseudoephedrine (Sudafed)	PO (elixir or tabs)	Per label instructions by age/weight		Yes No	
Guaifenesin (Robitussin)	PO (syrup)	Per label instructions by age/weight		Yes No	
Dyphenhydramine (Benadryl)	PO (chewable tabs, elixir, or pills)	Per label instructions by age/weight	Q 6 hr prn for allergic reaction (hives, insect bite)	Yes No	
Generic cough drops	PO	Per label instructions by age/weight	Q 4 hr prn for cough	Yes No	
Sore throat remedy (Chloraseptic)	PO (liquid or lozenges)	Per label instructions by age/weight		Yes No	
Lice shampoo (Rid)	topical	Per label instructions by age/weight		Yes No	
Laxatives for constipation (Milk of Magnesia)	PO (chewable tabs or liquid)	Per label instructions by age/weight		Yes No	
Maalox Plus, Mylanta, Tums	PO (chewable tabs or liquid)	Per label instructions by age/weight	BID-TID prn for stomach upset	Yes No	
Calamine Lotion	topical	Per label instructions by age/weight		Yes No	
Hydrocortisone 1% cream (CortAid)	topical	Per label instructions by age/weight		Yes No	
Topical antibiotic cream	topical	Per label instructions by age/weight		Yes No	
Biofreeze	topical	Per label instructions by age/weight		Yes No	

**PRESCRIPTION MEDICATIONS** Please list patient’s current regimen—both scheduled and prn medications. “Medication” is any substance a person takes to maintain and/or improve their health. This includes vitamins and natural remedies. **Keep ALL medications in the original packaging. Prescription medications must show name of participant, physician, name of medication, dosage, and frequency of use.** Provide enough medication to last the entire camp stay.

This participant will not take any daily medications while attending camp.  This participant will take the following daily medication(s) while attending camp.

DRUG	ROUTE	DOSAGE	SCHEDULE AND INDICATIONS	COMMENTS

**FORM B pages 1 and 2 completed by:**

Name \_\_\_\_\_

Title \_\_\_\_\_

License Number \_\_\_\_\_

Office Address \_\_\_\_\_

Phone \_\_\_\_\_ Date \_\_\_\_\_