Upper New York
CAMP & RETREAT
Ministries

# HEALTH HISTORY & AUTHORIZATION FORM

DATE(S) OF PROGRAM_____

NAME OF PROGRAM_____

The information on this form is not part of the camper acceptance process, but is gathered to assist us in identifying appropriate care. Health History must be filled out by parents/guardians of minors and is required annually. A physical exam must be completed by licensed medical personnel within 12 months of arrival at camp.
Please return all forms—**to the site you will be attending first**—at least three (3) weeks prior to arrival at camp.
A late fee of $15 will be charged for health forms that are not received at least five (5) days prior to arrival.

PARTICIPANT'S NAME_____ DATE OF BIRTH_____ AGE AT CAMP_____

HOME ADDRESS_____
*Street Address* *City* *State* *Zip*

SOCIAL SECURITY NUMBER OF PARTICIPANT (Optional)_____ GENDER: ☐ MALE ☐ FEMALE ☐ NON-BINARY

PARENT/GUARDIAN WITH LEGAL CUSTODY TO BE CONTACTED IN CASE OF ILLNESS OR INJURY

NAME_____ RELATIONSHIP TO PARTICIPANT_____

CELL PHONE_____ HOME PHONE_____ WORK PHONE_____

PRIMARY ADDRESS_____
*(If different from above)* *Street Address* *City* *State* *Zip*

SECOND PARENT/GUARDIAN OR OTHER EMERGENCY CONTACT

NAME_____ RELATIONSHIP TO PARTICIPANT_____

CELL PHONE_____ HOME PHONE_____ WORK PHONE_____

ADDITIONAL CONTACT IN EVENT PARENT(S)/GUARDIAN(S) CAN NOT BE REACHED

NAME_____ RELATIONSHIP TO PARTICIPANT_____

CELL PHONE_____ HOME PHONE_____ WORK PHONE_____

IS PARTICIPANT COVERED BY HEALTH INSURANCE? ☐ YES ☐ NO *(If "yes", please provide the following. Inlude a copy of your insurance card if appropriate)*

NAME OF INSURANCE COMPANY_____ GROUP NUMBER_____

NAME OF SUBSCRIBER_____ INSURANCE PHONE NUMBER_____

NAME OF PARTICIPANT'S PHYSICIAN_____ PHONE NUMBER_____

ADDRESS_____

NAME OF PARTICIPANT'S DENTIST/ORTHODONTIST_____ PHONE NUMBER_____

ADDRESS_____

## **IMPORTANT—SIGNATURE MUST BE PRESENT FOR ATTENDANCE**

**Parent/Guardian 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 physician. I hereby give permission to the camp to provide routine health care, administer standing orders, and seek emergency medical treatment if necessary. If I cannot be reached in an emergency, I give my permission to the providers selected by the camp to hospitalize, secure proper treatment for, and order x-rays, injection, anesthesia, or surgery for this camper. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my camper. 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, the camp has permission to obtain a copy of my camper's health record from providers who treat my camper and these providers may talk with the camp's staff about my camper's health status. I understand I will be contacted if my camper is exposed to a communicable disease or if outside medical attention is necessary.

I give permission for my camper/participant to carry and self apply: SUNSCREEN ☐ YES ☐ NO BUG REPELLENT ☐ YES ☐ NO
I give permission for camp staff to assist in the application of: SUNSCREEN ☐ YES ☐ NO BUG REPELLENT ☐ YES ☐ NO

I understand that the following conditions must be met in order to promote proper and safe use of sunscreen and bug repellent at camp: 1) the sunscreen will only be used to prevent overexposure to the sun; 2)the bug repellent will only be to used to prevent excessive exposure to bugs and ticks; 3) only sunscreen and bug repellent approved by the FDA for over-the-counter use will be permitted for use by the camper/participant.

Signature of custodial parent/guardian OR adult participant_____

Printed Name_____ Date_____

LAST NAME, FIRST NAME

Program

Week

# HEALTH HISTORY

PARTICIPANT'S NAME_____

The following information must be filled in ***by the custodial parent/guardian*** of the participant. The intent of this information is to provide camp health care personnel the background to provide appropriate care. *Any new information should be provided to the camp health care personnel upon participant's arrival in camp.*

## GENERAL HEALTH QUESTIONS (Check "Yes" or "No" for each statement. Explain "Yes" answers below.)

Has/does the participant:

1. Ever been hospitalized? ☐ YES ☐ NO
2. Ever had surgery? ☐ YES ☐ NO
3. Ever have a chronic or recurring illness/condition? ☐ YES ☐ NO
4. Had a recent infectious disease? ☐ YES ☐ NO
5. Had a recent injury? ☐ YES ☐ NO
6. Ever had asthma/wheezing/shortness of breath? ☐ YES ☐ NO
7. Have diabetes? ☐ YES ☐ NO
8. Have high blood pressure? ☐ YES ☐ NO
9. Ever have seizures? ☐ YES ☐ NO
10. Have frequent headaches? ☐ YES ☐ NO
11. Wear glasses, contacts, or protective eye wear? ☐ YES ☐ NO
12. Wear an orthodontic appliance? ☐ YES ☐ NO
13. Had fainting or dizziness? ☐ YES ☐ NO
14. Passed out/had chest pain during exercise? ☐ YES ☐ NO
15. Had mononucleosis ("mono") during the past 12 months? ☐ YES ☐ NO
16. If menstruating, have problems with periods/menstruation? ☐ YES ☐ NO
17. Have problems with falling asleep/sleepwalking? ☐ YES ☐ NO
18. Ever had back/joint problems? ☐ YES ☐ NO
19. Have a history of bedwetting? ☐ YES ☐ NO
20. Have problems with diarrhea/constipation? ☐ YES ☐ NO
21. Have skin problems (e.g., itching, rash, acne)? ☐ YES ☐ NO
22. Traveled outside the country in the past 9 months? ☐ YES ☐ NO
23. Ever been treated for emotional or behavioral difficulties or an eating disorder? ☐ YES ☐ NO
24. During the past 12 months, seen a professional to address mental/emotional health concerns? ☐ YES ☐ NO

Please explain any "yes" answers, noting the number of the question above:

Describe any ***restrictions*** with activities at camp:

# ILLNESS HISTORY

Check the box of any illnesses the participant has had:

☐ Measles ☐ Chicken Pox ☐ German Measles ☐ Mumps ☐ Hepatitis A ☐ Hepatitis B
☐ Hepatitis C ☐ Mono ☐ Covid-19 ☐ Other (please explain)

# IMMUNIZATION HISTORY

Provide the month and year for each immunization. Starred (✶) immunizations must include date to meet ACA Standard. Copies of immunization forms from health-care providers or state or local government are acceptable; please attach to this form.

| Immunization | | Dose 1 Month/Year | Dose 2 Month/Year | Dose 3 Month/Year | Dose 4 Month/Year | Dose 5 Month/Year | Most Recent Dose Month/Year |
|---|---|---|---|---|---|---|---|
| Diptheria, tetanus, pertussis (DTaP) or (TdaP) | | | | | | | |
| ✶ Tetanus booster (dT) or (TdaP) | | | | | | | |
| Mumps, measles, rubella (MMR) | | | | | | | |
| Polio (IPV) | | | | | | | |
| Haemophilus influenzae type B (HIB) | | | | | | | |
| Pneumococcal (PCV) | | | | | | | |
| Hepatitis B | | | | | | | |
| Hepatitis A | | | | | | | |
| Meningococcal meningitis (MCV4) | | | | | | | |
| Covid-19 | | | | | | | |
| Varicella (chicken pox) | ☐ Had chicken pox Date: | | | | | | |

| Tuberculosis (TB) test | Date: | ☐ Negative | ☐ Positive |
|---|---|---|---|

## ALLERGIES

PARTICIPANT'S NAME_____

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

## DIETARY RESTRICTIONS/NEEDS

Please list any dietary restrictions/needs the camper will have at camp:

## MENTAL, EMOTIONAL, AND SOCIAL HEALTH

Please use this space to provide any additional information about the participant's mental, emotional, behavioral, or social health about which the camp should be aware:

## MEDICATIONS

☐ Participant will not take any medications regularly while attending camp
☐ Participant will take medication(s) regularly while at camp

***ALL medications (e.g., prescriptions, non-prescriptions/over-the-counter, and vitamins) must be in their original container and accompanied by a physician's written order****—see the Standing Orders and Physical Examination form.* ***NO MEDICATIONS*** *may be administered at camp without a signed physician's order per New York State law.*

## FOR CAMP HEALTH CARE STAFF USE ONLY

☐ Health form has been reviewed and is complete. Reviewed by:_____ Date:_____
☐ Health form has been reviewed and needs the following:

### SCREENING UPON ARRIVAL TO CAMP

☐ Any updates/corrections/additions to this health history?
☐ Any recent exposure to communicable disease?
☐ Any signs/symptoms of illness or injury?
☐ Any signs/symptoms of head lice?
☐ Are all medications checked in?
☐ Allergy and dietary information shared with appropriate staff?

Screening Notes:

Screened by: _____ Date:_____

# ADDITIONAL NOTES

Please use this page to provide any additional notes about the participant's health:

Upper New York
CAMP & RETREAT Ministries

# STANDING ORDERS

NAME OF PARTICIPANT_____

DATE OF BIRTH_____ PROGRAM(S)_____

*The sections below **MUST** be completed by a licensed **PHYSICIAN** and is **REQUIRED** for participant **ATTENDANCE**.*
***This Standing Orders form must be completed each year.***

***Attention Physician:*** The following non-prescription/over-the-counter medications may be stocked in the camp infirmary/health center. Administration of these medications is "per label directions" unless otherwise noted. Generic drugs may be used in place of name brands.
Please check "yes" for medications the Site Medical Staff is allowed to administer to the participant, as needed.

| | | |
|---|---|---|
| ☐ YES | ☐ NO | Acetaminophen (discomfort/fever, headache, pain relief) |
| ☐ YES | ☐ NO | Ibuprofen (discomfort/fever, menstrual cramps, headache, muscle aches) |
| ☐ YES | ☐ NO | Hydrogen Peroxide/Antiseptic Solution (topical, wound cleaning) |
| ☐ YES | ☐ NO | Bacitracin/Neomycin/Polymyxin (topical, antibiotic ointment) |
| ☐ YES | ☐ NO | Calamine Lotion (topical, skin irritation) |
| ☐ YES | ☐ NO | Hydrocortisone Cream (topical, skin irritation) |
| ☐ YES | ☐ NO | Maximum Strength Calamine Cream (topical, skin irritation) |
| ☐ YES | ☐ NO | Benzocaine-Menthol Lozenges (throat irritation, cough) |
| ☐ YES | ☐ NO | Phenol Oropharyngeal (throat irritation) |
| ☐ YES | ☐ NO | Dextromethorphan or Guaifenesin (cough suppressant, cough expectorant) |
| ☐ YES | ☐ NO | Tetrahydrozoline Hydrochloride HCl (eye irritation) |
| ☐ YES | ☐ NO | Diphenhydramine (topical for skin irritation, oral for allergies/allergy, cold symptoms) |
| ☐ YES | ☐ NO | Cetirizine (allergies/allergy symptoms) |
| ☐ YES | ☐ NO | Loratadine (allergies/allergy symptoms) |
| ☐ YES | ☐ NO | Pseudoephedrine (allergies/allergy symptoms, sinus, cold symptoms) |
| ☐ YES | ☐ NO | Loperamide (diarrhea, cramps, bloating) |
| ☐ YES | ☐ NO | Simethicone (heartburn, acid indigestion, sour stomach, gas) |
| ☐ YES | ☐ NO | Calcium Carbonate (heartburn, sour stomach, acid indigestion, upset stomach) |
| ☐ YES | ☐ NO | Bismuth Subsalicylate (nausea, heartburn, indigestion, upset stomach, diarrhea) |
| ☐ YES | ☐ NO | Magnesium hydroxide (constipation) |
| ☐ YES | ☐ NO | Menthol cough drops (throat irritation) |
| ☐ YES | ☐ NO | Lice shampoo or cream (for treatment of lice) |
| ☐ YES | ☐ NO | Sunscreen (to prevent overexposure to the sun; must be FDA approved) |
| ☐ YES | ☐ NO | Bug repellent (to prevent excessive exposure to bugs and ticks; must be FDA approved) |

## ALL PRESCRIPTION AND ANY ADDITIONAL OVER-THE-COUNTER MEDICATIONS *(attach additional sheets as necessary)*

| Name of Medication | Dosage | Route (How it is given) | Schedule (When it is given) | Reason for taking it/ Comments directed by MD |
|---|---|---|---|---|
| | | | ☐ Breakfast<br>☐ Mid-day Meal<br>☐ Evening Meal<br>☐ Bedtime<br>☐ Other: | |
| | | | ☐ Breakfast<br>☐ Mid-day Meal<br>☐ Evening Meal<br>☐ Bedtime<br>☐ Other: | |
| | | | ☐ Breakfast<br>☐ Mid-day Meal<br>☐ Evening Meal<br>☐ Bedtime<br>☐ Other: | |

*** MEDICATIONS MUST BE IN ORIGINAL CONTAINERS ***

A PHYSICIAN and a PARENT/GUARDIAN SIGNATURE are required by New York State Department of Health in order to allow the Site Medical Staff to administer ANY and ALL medications checked "YES"

*Date of Standing Orders*_____ *Phone*_____ *License #*_____

*Signature of PHYSICIAN*_____

*Printed name*_____

Signature of custodial parent/guardian OR adult participant_____

Printed Name_____ Date_____

*Please return all forms—to the site you will be attending first—at least three (3) weeks prior to arrival at camp.*
*A late fee of $15 will be charged for health forms that are not received at least five (5) days prior to arrival.*

*This form can be faxed to :*
Sky Lake Office - (607) 467-4612

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# PHYSICAL EXAMINATION

NAME OF PARTICIPANT_____

DATE OF BIRTH_____ PROGRAM(S)_____

*The sections below **MUST** be completed by a licensed **PHYSICIAN** and is **REQUIRED** for participant **ATTENDANCE**.*
The examination must be ***within 12 months (1 year)*** of the participant's entire stay/time at camp.
** If there is a copy of a physical from the camper's Physician, Health Clinic, School or Sports Physical, please attach.**
**If no physical examination is attached, PHYSICIAN must complete this form for camper to attend camp session.**

## EXAMINATION

Date of Physical Examination_____

Height_____ Weight_____ BP_____

General appraisal:

Known allergies (please specify):

Special Considerations:

Restrictions while attending camp:

Other

***I have examined the person herein described and it is my opinion that the individual is physically able to engage in all camp activities, except as noted above.***

*Date of Signature*_____ *Phone*_____ *License #*_____

*Signature of PHYSICIAN*_____

*Printed name*_____

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

Signature of participant/camper_____ Date_____

*Please return all forms—to the site you will be attending first—at least three (3) weeks prior to arrival at camp.*
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