2017 CAMP WARWICK HEALTH RECORD

THE HEALTH RECORD MUST BE COMPLETED IN FULL AND INCLUDED WITH THE REGISTRATION FORM AND THE SIGNED NOTARIZATION FORM BEFORE REGISTRATION WILL BE ACCEPTED.

Camper Last Name _____ Camper First Name _____ Initial _____

Family Physician _____ Physician's Telephone _____

Health Insurance Co. _____ Type of Policy _____ Policy # _____

Policy Holder Name and Address _____

Policy Holder's Date of Birth ___/___/___ Name of Employer Associated with Policy _____

Attach a photocopy of the insurance card (front and back). Employer Phone # _____

Prescription drug policy? ❑ Yes ❑ No If yes, attach a photocopy of the prescription card (front and back).

PLEASE NOTE: The Warwick Conference Center / Camp Warwick is not responsible for the cost of prescriptions, doctor visits, or emergency room visits during your camp stay.

*** FILL IN ALL INFORMATION ***

MEDICAL INFORMATION

Is your child in general good health and able to participate in all normal camp activities? ❑ Yes ❑ No

ADD	❑ Yes ❑ No	Heart Murmur	❑ Yes ❑ No	Throat problems	❑ Yes ❑ No
ADHD	❑ Yes ❑ No	As infant	❑ Yes ❑ No	Respiratory problems	❑ Yes ❑ No
Seizures/Epilepsy	❑ Yes ❑ No	Current problems	❑ Yes ❑ No	Diabetic	❑ Yes ❑ No
Dizzy spells	❑ Yes ❑ No	Chest Pain	❑ Yes ❑ No	Special diet	❑ Yes ❑ No
Motion sickness	❑ Yes ❑ No	Irregular Heartbeat	❑ Yes ❑ No	Frequent nausea	❑ Yes ❑ No
Chronic back pain	❑ Yes ❑ No	Low/high blood pressure	❑ Yes ❑ No	Jaundice/Hepatitis	❑ Yes ❑ No
Neck pain	❑ Yes ❑ No	Ear infections	❑ Yes ❑ No	Difficulty urinating	❑ Yes ❑ No
Homesickness	❑ Yes ❑ No	Hearing problems	❑ Yes ❑ No	Kidney infection	❑ Yes ❑ No
Special needs	❑ Yes ❑ No	Vision problems	❑ Yes ❑ No	Hernia	❑ Yes ❑ No
Hyperactive	❑ Yes ❑ No	Severe menstrual cramps	❑ Yes ❑ No	Behaviorial Issues	❑ Yes ❑ No
Emotional Issues	❑ Yes ❑ No	Asthma	❑ Yes ❑ No	Digestive Issues	❑ Yes ❑ No

Auto-Immune Conditions ❑ Yes ❑ No

FOR GIRLS: Been told about menstruation? ❑ Yes ❑ No Has menstruated? ❑ Yes ❑ No

Please give specific information and current status regarding any items marked "yes" above.

_____

_____

_____

MEDICAL HISTORY - PLEASE LIST DETAILS & DATES BELOW. USE ADDITIONAL SEPARATE PAGE IF NEEDED.

Have you ever been hospitalized? ❑ Yes ❑ No If yes, reason and date: _____

Chronic recurring illness _____ Any broken bones _____

Severe head, neck or back injury_____ Date:_____

Contagious diseases _____ Date:_____

Serious operations (list date/type)_____ Date:_____

Recent illness/injury_____ Date:_____

Please submit statement of how your child has been medically treated and with what medication.

*FILL IN **ALL** INFORMATION*

CAMPER NAME: _____

FOOD ALLERGIES

List food(s) your child is allergic to: _____

_____

What type of reaction does your child experience when ingesting these foods?

Hives ❑ Yes ❑ No Anaphylactic Shock ❑ Yes ❑ No GI Disturbance ❑ Yes ❑ No

What treatment is given?

None ❑ Yes ❑ No Benadryl ❑ Yes ❑ No Epi-pen* ❑ Yes ❑ No

Is your child able to self-administer epi-pen? ❑ Yes ❑ No Other: _____

_____

Requires a doctor's order. Complete Medical Authorization Form sent in confirmation packet.

Camp Warwick makes every attempt to accommodate food allergies and sensitivities. However, in cases of potential life-threatening allergies families are encouraged to send their own food and snacks. We encourage you to call two weeks prior to your child attending camp to discuss specific arrangements at 845-986-1164. Ask for Arlene Tenckinck.

SKIN ALLERGIES

❑ Yes ❑ No If "yes", please list:_____

_____

MEDICATION ALLERGIES

List any prescription or over-the-counter medications that your child is allergic to: _____

_____

_____

OTHER ALLERGIES

Bee Sting ❑ Yes ❑ No Poison Ivy/Oak/Sumac ❑ Yes ❑ No

Hay Fever ❑ Yes ❑ No Suntan Lotion ❑ Yes ❑ No

Reaction: _____

Treatment: _____

IMMUNIZATIONS

New York State requires your child to have the following immunizatons. **PLEASE ATTACH AN OFFICIAL IMMUNIZATION RECORD FROM THE CHILD'S DOCTOR'S OFFICE.**

DPT Varicella M.M.R. Hepatitis B Series Oral Polio Vaccine HIB

All immunizations are required unless a) it is medically contraindicated (doctor's signature required) or b) choose not to for religious reasons (documentation by religious leader necessary).

MEDICATIONS / CAMP WARWICK CAMPERS - USE ADDITIONAL SEPARATE PAGE IF NEEDED

List any medication (prescription and over-the-counter) that your child is currently taking: _____

_____

_____

I give permission to the Camp Warwick Health Director to supervise the self-medication of the following: *(Check off)*

❑ Antacids / Tums ❑ Cold medications ❑ Tylenol ❑ Ibuprofen (Advil or Motrin)

❑ Cough syrup/drops ❑ External ointments ❑ Suntan lotion ❑ Benadryl

Other over-the-counter medications (list):_____

_____

The Camp Warwick Health Director will supervise the self-medication of prescription and over-the-counter medicines by campers at on-site camps and oversee the First Aid personnel of off-site camps in the distribution of medicine. All medications (prescription and over-the-counter) must be given to the Health Director at the time the camper checks in. The Health Director stocks most common medications such as Tylenol and cold remedies, so it is not necessary to bring them to camp. All prescription medications must be in the original container, labeled with the camper's name, and written instructions signed by your physician must accompany the medication. All over-the-counter medications must be in the original container and labeled with the camper's name. A **USE OF MEDICATION POLICY**