Team Name________________________________ Week #_____

Catskill Camp Services, Inc.
Camper Information

This side to be completed by parent or guardian:

Child:

Last Name ____________________First Name________________ Sex____ DOB_______
Address____

Parent:

Last Name _________________ First Name __________________ Home Phone___________
Address____ Cell Phone ____________
Work Phone___________

Second Contact:

Last Name _________________ First Name __________________ Home Phone___________
Address____ Cell Phone ___________ Relationship
____ Work Phone___________

If parent / guardian is coming to Cooperstown where are they staying:
____Phone #_____________

Health History:

Yes	No		
☐	☐	**Asthma:**	Mild Moderate Severe Exercise induced
☐	☐	**Allergies**	Please list __________________________________
☐	☐	**Diabetes**	
☐	☐	**Seizure disorder**	
☐	☐	**Heart Disease**	Please explain________________________________
☐	☐	**Other History**	Please explain________________________________

Immunization History: Most recent date of immunization

MMR ___/___/___ Polio ___/___/___ DPT ___/___/___

Hepatitis B Series completed ___/___/___ Haemophilus Influenza Type b ___/___/___

Chicken Pox (Varicella) vaccine date ___/___/___ or Disease date___/___/__

A copy of immunization history is acceptable.

Please attach a photocopy of your camper's insurance card.

IMPORTANT – THIS CONSENT MUST BE COMPLETED FOR ATTENDANCE

This health history is correct so far as I know, and the person herein described has permission to engage in all camp activities except as noted. In the event of serious illness or injury I hereby give CATSKILL CAMP SERVICES, INC. permission to provide emergency treatment and referral to a hospital in the event I cannot be reached. I hereby give permission to the physician selected by the camp health director to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for my child as named above. This form may be photocopied for use out of camp.

Signature of parent/ guardian________________________________ Date_____________

Catskill Camp Services, Inc.
Camper Examination and Medications

Camper's Name________________________________ Date of Birth___________
Team Name __________________________________

This form is to be completed by a Physician, Physician Assistant or Nurse Practitioner.

I examined this individual on __________ (must be within 12 months from the start of camp). In my opinion, the above camper ☐ is ☐ is not able to participate in an active camp program.
The camper is under the care of a physician for the following conditions:
____

Treatments to be continued at Camp: ____
____

Medications:
New York State Department of Health requires that camps have an individualized set of standing orders for each camper attending camp. The list below is of the standard over the counter medications campers may require while at camp. The medications will only be administered at the discretion of a Registered Professional Nurse. A licensed health care provider needs to initial in the Yes box if they wish the child to be eligible to receive the medication at camp and sign the bottom of this form.

☐ Yes ☐ No Acetaminophen PO per label instructions by age/weight every four hours as needed for pain or fever >100.5
☐ Yes ☐ No Ibuprofen PO per label instructions by age/weight every 6 hours as needed for pain or fever >101.5
☐ Yes ☐ No Diaphenhydramine PO per label instructions by age/weight every 4-6 hours as needed for allergies
☐ Yes ☐ No Mylanta PO per label instructions by age/weight three to four times a day as needed for an upset stomach.
☐ Yes ☐ No Dimetapp PO per label instructions by age/weight every 6-8 hours as needed for nasal congestion /drainage.
☐ Yes ☐ No Robitussin PO per label instructions by age/weight every 4 hours as needed for cough.

Daily/ Prescribed Medications and PRN medications the child will need while at camp.

Drug Name	Route	Dose	Schedule/ Indication	Comments

All Medications Must be in the original containers.

Health Care Providers Name: ______________________________ Phone #_________
Address______________________________________ License # ________________

Health Care Providers Signature ____________________________ Date ___________