

Team Number \_\_\_\_\_ 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					
<input type="checkbox"/>	<input type="checkbox"/>	<b>Asthma:</b>	Mild	Moderate	Severe	Exercise induced
<input type="checkbox"/>	<input type="checkbox"/>	<b>Allergies</b>	Please list _____			
<input type="checkbox"/>	<input type="checkbox"/>	<b>Diabetes</b>				
<input type="checkbox"/>	<input type="checkbox"/>	<b>Seizure disorder</b>				
<input type="checkbox"/>	<input type="checkbox"/>	<b>Heart Disease</b>	Please explain _____			
<input type="checkbox"/>	<input type="checkbox"/>	<b>Other History</b>	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 Diphenhydramine 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 \_\_\_\_\_

Provider and/or practice stamp: