Unirondack Staff Medical Form 2012

Instructions

This is a fill-in form that can be typed into directly. Because parts of the form require a signature from you or a parent or guardian, and a doctor, it must be printed and mailed after completion, rather than e-mailed. Please mail the completed form, including your immunization record, to **Unirondack, P.O. Box 795, Nyack, NY 10960 prior to May 1**. If for any reason you cannot complete the form on time please e-mail us at Director@Unirondack.org.

FAMILY AND STAFF MEMBER INFORMATION

Please complete all sections. It is important that we be able to contact your parent or spouse and provide care in the event of an emergency. We strongly urge you to share any pertinent information about yourself if you have special needs. This allows us to advise you about our ability to meet your needs and greatly increases the probability that your experience at camp as a staff member will be a positive one.

INSURANCE DETAILS

Please fill in the health insurance information and **attach a photocopy of your health insurance card.**

EMERGENCY CONTACT DETAILS

These contacts should be extended family members or trusted friends who you would like us to contact in an emergency in the event that you are incapacitated. Please make certain to check the box indicating whether or not you are authorizing the emergency contact to make decisions about your medical care in the event that you cannot make decisions for yourself and your parent or spouse cannot be reached. If they are people who are likely to know your parent or spouse's whereabouts that is especially helpful.

MEDICAL ORDERS and IMMUNIZATION RECORD

Please have your **doctor** fill out and **sign** the medical orders, which allow us to administer medicine to you. Also, please obtain your **immunization record and attach it to this form.**

MENINGITIS VACCINATION

Please read and check the appropriate box and **sign** or have your parent sign.

DECLARATION

Please read and **sign or have your parent sign** the declaration at the end of the form. Thank you.

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Mail all 4 pages of form and immunization record and copy of insurance card to:
Unirondack, P.O. Box 795 Nyack, NY 10960

STAFF MEMBER INFORMATION

Name: ____

DOB: ____________ Age in June: ___________ Sex: ___________ Weight: ___________

FAMILY INFORMATION (Fill out for self and spouse if not still dependent of parents)

Parent/Guardian/Self: ______________________________ Relationship: ______________

Home Phone: _________________ Work: _________________ Cell: ________________

Address: ____

Parent/Guardian/Spouse: ___________________________ Relationship: ______________

Home Phone: ________________ Work: _________________ Cell: _________________

Address: ____

EMERGENCY CONTACTS

Name: ____________________________________ Relationship: ______________________

Address: ____

Home Phone: ________________ Work: _________________ Cell: _________________

☐ I authorize this person to make medical decisions on my behalf in the event that I am incapacitated, or if I cannot be reached and am signing this form as a parent of a staff member.

Name: ____________________________________ Relationship: _____________________

Address: ____

Home Phone: ________________ Work: _________________ Cell: _________________

☐ I authorize this person to make medical decisions on my behalf in the event that I am incapacitated, or if I cannot be reached and am signing this form as a parent of a staff member.

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Staff Member ______________________________

MEDICAL CONDITIONS, LIMITATIONS, ALLERGIES

Please answer YES or NO:

Asthma_____ Diabetes_____ Seizures ______ Bleeding/Clotting _______ Heart Disease _______

Please list any other Conditions or Limitations:

____

Dietary Requirements: Vegetarian________ Vegan__________ Other_______________________

Allergies to foods/Special Requirements____

Special Needs *(Please describe any emotional, behavioral, physical or other special needs or conditions. Include any situations of stress or special changes in your [illegible].):*

____

PRIMARY PHYSICIAN INFORMATION

Name: ____ Phone: __________________________

Address:____

OTHER TREATMENT PROFESSIONALS:____

____

MEDICAL INSURANCE (Please attach a copy of your insurance card to this form!)

Primary Insured: ____

Insurance Company: ____

Group ID: ___________________________ Policy Number: __________________________________

Insurance Company Phone Number____

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INDIVIDUALIZED MEDICAL ORDERS *(must be signed by physician)*

Please indicate by circling Yes or No whether the following medications can be administered to the staff member at the discretion of the Camp's Healthcare Provider/EMT.

Drug Name	**Route** (Circle preferred formulations)	**Dosage**	**Schedule and Indications**	**Healthcare Provider Order**	**Comments**
Pseudoephedrine hydrochloride (Sudafed)	PO (Tablets)	Per label instructions by age/weight	Q 4 hours prn for nasal congestion	**Yes** ☐ **No** ☐	
Acetaminophen (Tylenol)	PO (chewable tabs, elixir, or tablets)	Per label Instructions by age/weight	Q 4 hours prn for pain or fever	**Yes** ☐ **No** ☐	
Ibuprofen	PO (chewable tabs, suspension)	Per label instructions by age/weight	Q 6 hours prn for pain or fever	**Yes** ☐ **No** ☐	
Kaopectate	PO (suspension or tablets)	Per label instructions by age/weight	Q 2 hours prn for diarrhea	**Yes** ☐ **No** ☐	
Diphenhydramine (Benadryl)	PO (elixir, chewable tabs,suspension, or pills)	Per label instructions by age/weight	Q 6 hours prn for allergic reactions (hives,insect bite)	**Yes** ☐ **No** ☐	
Robitussin DM	PO (syrup)	Per label instructions by age/weight	Q 4 hours prn for cough	**Yes** ☐ **No** ☐	
Mylanta/Tums	PO (chewable tabs)	Per label instructions by age/weight	Q 4 hours prn for stomach upsets	**Yes** ☐ **No** ☐	
Epinephrine (Epipen)	IM	Per label instructions 0.3 ml or 0.1 ml	Per NYS DOH protocol for anaphylaxis	**Yes** ☐ **No** ☐	

Please give details of any prescription/other medications that the staff member is currently taking and the camp's healthcare provider will be required to administer (attach copy of prescription if available):

Drug	**Route**	**Dosage**	**Schedule and Indications**	**Comments**

Additional orders as deemed necessary by physician (dressing changes, cast care, etc):

____

Physician Name (Print)_______________________________**Phone**_______________________

Physician Signature:_________________________________ **Date**_________________________

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Staff Member Name_______________________________

IMMUNIZATION RECORDS

Please attach a photocopy of your immunization record to this form.
The NYS Dept. of Health requires a complete record of all immunizations received prior to working at Unirondack. We require dates of the following Immunizations: **Tetanus, DPT, Polio, Measles, Mumps, Haemophilius Influenza type A, Hepatitus B**, and a vaccine or the date of the following Diseases: **Chicken Pox and German Measles**.

MENINGITIS VACCINATION

New York State Public Health Law requires that all parents or guardians of residential summer camp staff members complete and return the following certification if that staff member is still a dependent. Check one box and sign below.

☐ My child has had the meningococcal meningitis immunization (Menomune) within the past 10 years.
Date received: _____________________

(**NOTE:** If your child received the meningococcal vaccine available before February 2005 called Menomune, please note the vaccine's protection lasts for approximately 3 to 5 years. Revaccination with the conjugate vaccine Menactra should be considered within 3-5 years after receiving Menomune.)

☐ I have read, or have had explained to me, the information regarding meningococcal meningitis disease. My child will obtain immunization against meningococcal meningitis within 30days from my private health care provider.

☐ I have read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that my child (or self) will not obtain immunization against meningococcal meningitis disease.

Staff Member or Parent's Signature: ______________________________________**Date:** ________________

DECLARATION

I, as parent/guardian of the above named UNIRONDACK staff member, or as myself if no longer the dependent of a parent, do hereby certify that I have accurately listed all known medical conditions, limitations or allergies above. I give my permission to the Director, or the designated Unirondack Healthcare Provider/EMT, to authorize emergency medical treatment for me if my parent or spouse cannot be reached at the above contact numbers. I give permission to Unirondack, Inc. to follow the medical orders from Dr. ________________

I agree to accept financial responsibility for all medical care provided.

I understand that any medications can only be dispensed if they are handed in at Unirondack in their original container with the physician's instructions printed on it.

I understand that Unirondack may release any staff member employed by the camp who has health, emotional, behavioral or physical needs that can not be handled safely or appropriately at Unirondack.

Name __________________________**Signed** _____________________________**Date**_______________