CAMP MORASHA MEDICAL FORM - TO BE FILLED OUT BY **PARENT**

infirmary@campmorasha.com
Winter Address: 1118 Ave J Brooklyn, NY 11230 - Tel: 718-252-9696 - Fax: 718-252-7369
Summer Address: 274 High Lake Road Lakewood, PA 18439 - Tel: 570-798-2781 - Fax: 570-798-2966

CAMPER/STAFF INFORMATION

Camper Name: _____

☐ Male ☐ Female ☐ Camper ☐ Staff ☐ Kollel

Date of Birth: _____ Age at Camp: _____

Home Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell # (For Staff Only): _____

EMERGENCY CONTACTS

Primary parent/guardian to be contacted in case of illness or injury:

MOM Name: _____ E-mail: _____

Cell # _____ Business # _____

DAD Name: _____ E-mail: _____

Cell # _____ Business # _____

Primary emergency contact, other than parents (**REQUIRED!**)

Name: _____ Relationship: _____

Home #: _____ Cell #: _____

Secondary emergency contact, other than parents (**REQUIRED!**)

Name: _____ Relationship: _____

Home #: _____ Cell #: _____

HEALTH CARE PROVIDERS

Primary Doctor: _____ Phone: _____

Dentist: _____ Phone: _____

Orthodontist: _____ Phone: _____

DIET / NUTRITION

☐ Eats a regular diet ☐ Eats a regular vegetarian diet

☐ Has special food needs: _____

A PHOTOCOPY OF FRONT & BACK OF **INSURANCE CARDS** (MEDICAL AND PHARMACY) ON THE ENCLOSED FORM MUST BE SUBMITTED!

This health history is correct and accurately reflects the status of the camper to whom it pertains. The person described has permission to participate in all activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. I also give permission for the camp to arrange related transportation. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with staff. I give permission to photocopy this form for trips out of camp. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status. If your camper has not been fully immunized, please sign the following statement: I understand and accept the risks to my child from not being fully immunized.

>> SIGNATURE of Parent/Guardian/Staff Member: _____

Printed Name: _____ **Date:** _____

GENERAL, MENTAL, EMOTIONAL, & SOCIAL HEALTH

Check "Yes" or "No" for each statement. Explain "Yes" below.

Is there a history of...

1. Hospitalizations? ☐ Yes ☐ No
2. Surgery? ☐ Yes ☐ No
3. Recurrent / chronic illnesses? ☐ Yes ☐ No
4. Recent infectious disease? ☐ Yes ☐ No
5. Recent injury? ☐ Yes ☐ No
6. Seizures? ☐ Yes ☐ No
7. Fainting or dizziness? ☐ Yes ☐ No
8. Headaches? ☐ Yes ☐ No
9. Fainting / chest pain during exercise? ☐ Yes ☐ No
10. Diarrhea / constipation problems? ☐ Yes ☐ No
11. Bedwetting? ☐ Yes ☐ No
12. Falling asleep/sleepwalking? ☐ Yes ☐ No
13. Back / joint problems? ☐ Yes ☐ No
14. Skin problems? ☐ Yes ☐ No
15. Diabetes? ☐ Yes ☐ No
16. Allergies? (List **SPECIFIC** food allergies and describe any reactions prescriptions etc. below) ☐ Yes ☐ No
17. Uses an epi pen? *Elaborate below*. ☐ Yes ☐ No
    If yes, can it be kept in bunk? ☐ Yes ☐ No
18. Asthma, wheezing, shortness of breath? ☐ Yes ☐ No
19. Uses an inhaler? ☐ Yes ☐ No
20. Outside country in the past 9 months? ☐ Yes ☐ No
21. Wears glasses or contacts? ☐ Yes ☐ No
22. Had "mono" in the past 12 months? ☐ Yes ☐ No
23. Problems with periods / menstruation? ☐ Yes ☐ No
24. Ever been treated for emotional or behavioral difficulties or an eating disorder? ☐ Yes ☐ No
25. The past 12 months, seen a professional to address mental/emotional health concerns? ☐ Yes ☐ No
26. Been treated for Attention Deficit Disorder (ADD) or Attention Deficit/Hyperactivity Disorder? ☐ Yes ☐ No
27. Had a life event that continues to affect the camper's life? (abuse, death of a loved one, divorce) ☐ Yes ☐ No

Please explain "Yes" answers in the space below:

_____

_____

_____

Does camper use inhaler or epi pen? If yes, **what they are allergic to**? ☐ No ☐ Yes, _____

Does camper take medication on a routine basis? ☐ No ☐ Yes

Medication_____ Dosage_____ Times Taken_____ Reason_____

Medication_____ Dosage_____ Times Taken_____ Reason_____

CAMP MORASHA MEDICAL FORM - TO BE FILLED OUT BY **DOCTOR**

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Full Name: _____ Date of Birth: _____ ☐ Camper ☐ Staff Member ☐ Kollel
MEDICAL PERSONNEL: Please review this form and complete all remaining sections below

Camp Morasha requires a physical exam dated within last 12 months.

IMMUNIZATION HISTORY: Provide the month and year for each immunization.

IMMUNIZATION	**DOSE 1** (month/year)	**DOSE 2** (month/year)	**DOSE 3** (month/year)	**DOSE 4** (month/year)	**DOSE 5** (month/year)
Diptheria, tetanus, pertussis (DTaP or TdaP)	_____	_____	_____	_____	_____
Mumps, measles, rubella (MMR)	_____	_____			
Polio (IPV)	_____	_____	_____	_____	
Haemophilus influenzae type B (HIB)	_____	_____	_____	_____	
Pneumococcal (PCV)	_____	_____	_____	_____	
Hepatitis B	_____	_____	_____		
Hepatitis A	_____	_____			
Varicella (Chicken Pox)	_____	_____	☐ Had chicken pox? Date: _____		
Meningococcal meningitis (MCV4)	_____				
Tetanus Booster (dT or TdaP)	Most Recent Dose: _____				

Physical exam done today? ☐ Yes ☐ No, date of last physical: _____

Weight: _____ Height: _____ Blood Pressure: _____ Pulse: _____

Chronic or current illness: _____

The camper is undergoing treatment at this time for the following conditions: _____

_____

DIET / NUTRITION / ACTIVITY

☐ Eats a regular diet ☐ Medically prescribed diet or dietary restrictions: _____

Do you feel that the camper will require limitations or restrictions to activity while at camp? ☐ No ☐ Yes: _____

_____

☐ No known allergies ☐ List all allergies reactions and treatments: _____

MEDICATION

☐ No daily medication ☐ Yes daily medication (Include name(s), dose(s), frequency and reason for taking): _____

_____

Other treatments / therapies to be continued at camp**:** _____

☐ Epipen Has history of ☐ Asthma ☐ Inhaler ☐ Other: _____

Physician Authorization:

It is my opinion that the camper is physically and emotionally fit to participate in an active camp program (except as noted above).

Address: _____ City: _____ State: _____ Zip: _____ Phone: _____

_____ _____

Name of Licensed Provider **Signature** **Date**

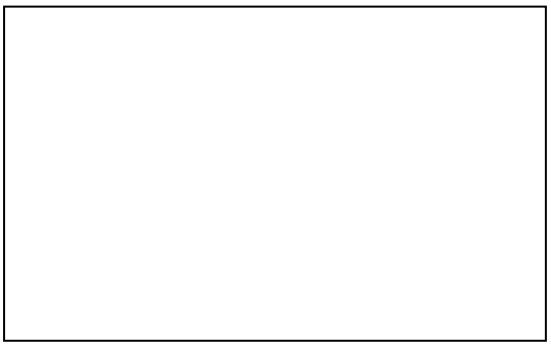
Medical Insurance

We require one copy of this form for every registered camper and staff member. Please make sure copy is legible!

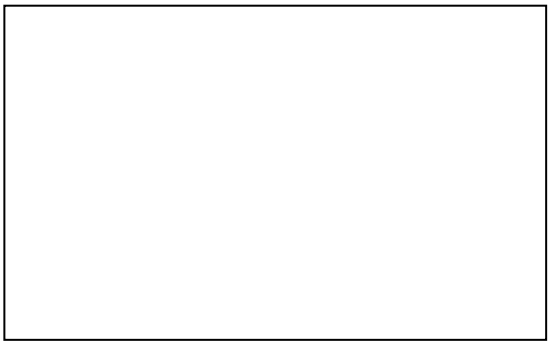
Name (as it appears on the policy): _____ ☐ Camper ☐ Staff ☐ Kollel

Birth Date: _____ ☐ Male ☐ Female

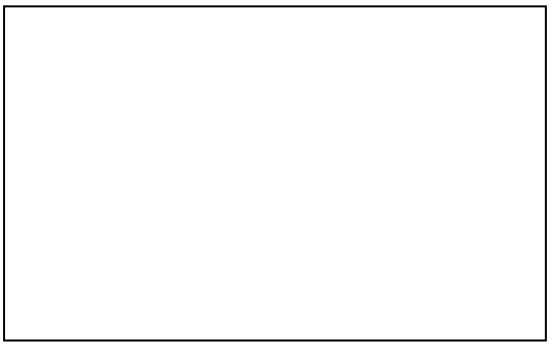
Name of Policy Holder: _____



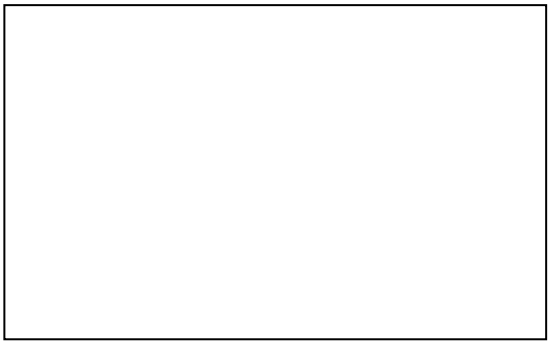
Front copy of health insurance card



Back copy of health insurance card



Front copy of pharmacy card



Back copy of pharmacy card

We will need the above information and, at times, CC info handy at hospitals, to give your child medical attention. Please be sure to affix a pharmacy card in addition to your health card. This is mandatory in order for your child to receive any prescriptions during camp.

Credit Card Type: _____

Card # _____ Exp. Date: _____

Please ensure that the credit card expires AFTER August 19, 2014!

MEDICATION PROCEDURE

Camp Morasha requires all our campers to have all of their medication (in pill/capsule/tablet form) blister packed/unit dosed by J Drugs. J Drugs is a neighborhood pharmacy that has been in business for over 25 years.

IF DAILY MEDS/VITAMINS ARE NOT BLISTERED PACK OR DIVIDED DAILY BEFORE THE SUMMER, THEY WILL NOT BE DISTRIBUTED AND THEY WILL BE SENT HOME IMMEDIATELY TO REMEDY THE ACT.

Medications required to be blister packed/unit dosed include:

- Medications taken on a daily basis (prescription and non prescription)
- All medicine taken "as needed"
- Vitamins AND ALL OVER THE COUNTER MEDICATION DISPENSED REGULARLY

This method of dispensing medicine has many positive benefits, including:

- Ensuring every camper gets the correct medication and dosage at the specified times
- Minimizing potential medication errors
- Expediting dispensing time, thus enabling campers to return to their activities sooner
- Avoiding discrepancies between what is prescribed and what the camper tells us
- Automatically reordering medications that may run out, thereby ensuring enough for the time in camp

Our affiliated licensed pharmacy accepts most insurance plans. They will verify the insurance and then bill for the prescription medication. However, parents will be responsible for co-payments and deductibles and the cost of any drugs not covered by their plan. The pharmacy will bill these charges to the responsible party's credit card (Visa and Master Card only) during the summer months. If the pharmacy is not a provider for the insurance plan and is unable to get reimbursed, the parent or responsible party will be notified prior to billing their credit card. Due to insurance regulations, only one month's medicine is dispensed at a time. We, therefore, urge you to supply a prescription with refills for those campers who stay a full season.

Please note: Controlled substances cannot be written with refills and these will require an additional prescription. The second month's supply will be shipped to camp automatically. As always, all unused medications will be send home at the end of the summer. THERE WILL BE A $5.00 CHARGE PER PRESCRIPTION FOR THE PRE-PACKAGING OF THE MEDICATIONS. If your prescription will not be due to be refilled at the time camp begins, please call J Drugs to discuss the issue at least 30 days in advance.

Please MAIL in your prescriptions to:
J DRUGS
1205 AVENUE J, BROOKLYN, NY 11230
Tel # 718- 258 6686

If you have any questions, you can contact the pharmacy via the above contact or email the camp at **infirmary@campmorasha.com**. In the subject heading, please type in ATTN: INFIRMARY.

We wish you an enjoyable and healthy summer.

MEDICATION DISPENSING

This form is used in setting up the infirmary. In order for us to know that your child will be receiving his or her medication(s) and not miss any doses, this form must be completed and returned to the camp office by June 10th.

Camper's Full Name: _____

Camper's name appears on prescription (if different): _____

Date of Birth: _____ ☐ Full ☐ July ☐ August

IF THE INFIRMARY HAS QUESTIONS, THEY CAN REACH ME AT:

Home Phone #: _____ Cell Phone #: _____

>> PLEASE SIGN BELOW: I agree to follow Morasha medication administration protocol, knowing that if I don't my child will not receive his or her daily medication until the medication dispense protocol is updated.

Sign here: _____

MEDICATION #1

Name of Medicine: _____

This medication is being prescribed for the following reason: _____

_____

Directions on when to take (dispensed after meals): ☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime

Special Directions (example: crush pills, take with juice, should meds be in fridge etc):_____

_____

If a camper forgets to take his or her medicine:

☐ Please do not call – it's ok to miss a dose.
☐ Please call my child to the infirmary. He or she cannot miss a dose.

MEDICATION #2

Name of Medicine: _____

This medication is being prescribed for the following reason: _____

_____

Directions on when to take (dispensed after meals): ☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime

Special Directions (example: crush pills, take with juice, should meds be in fridge etc):_____

_____

If a camper forgets to take his or her medicine:

☐ Please do not call – it's ok to miss a dose.
☐ Please call my child to the infirmary. He or she cannot miss a dose.

MEDICATION #3

Name of Medicine: _____

This medication is being prescribed for the following reason: _____

_____

Directions on when to take (dispensed after meals): ☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime

Special Directions (example: crush pills, take with juice, should meds be in fridge etc):_____

_____

If a camper forgets to take his or her medicine:

☐ Please do not call – it's ok to miss a dose.
☐ Please call my child to the infirmary. He or she cannot miss a dose.

J DRUGS PHARMACY FORM

PLEASE MAKE SURE ALL INFORMATION IS LEGIBLE. THANK YOU.

***Please attach each prescription and mail DIRECTLY to:**

J DRUGS
1205 Avenue J
Brooklyn, NY 11230
Tel. # 718-258-6686

Full Name of Camper _____ Date of Birth _____

Name of camper how it appears on insurance card / prescription: _____

Address _____

Parent Name _____ Home Phone # _____

Parent Cell # _____ Summer Contact # _____

Allergies_____

Name of Medicine _____ Dosage _____

What is the reason for taking this medication? _____

When is this medication taken at home? _____

This medication is taken ☐ Daily ☐ As needed basis

Please indicate dates of camp attendance:

July_____ August_____ Full_____ Other_____

Payment (Visa or MasterCard only)

Name on card _____

Please circle one: Visa / MasterCard

Credit Card Number_____ Exp Date: _____

Please attach a copy of both sides of your pharmacy insurance card. **Please make sure copy is legible**!

FRONT OF CARD

BACK OF CARD