Unirondack Medical Form 2014

Instructions

This is a fill-in form that can be typed into directly. Because parts of the form require a signature from a parent or guardian or a doctor, it must be printed and mailed after completion, rather than e-mailed. Please mail the completed form, including your child's 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 (such as a camper who is registering after May 1), please e-mail us at Director@Unirondack.org or call the office at 845-675-9001 to make special arrangements.

PHYSICAL EXAMINATION

There is NO requirement for a physical examination for camp. This form should be filled out and signed by a parent/guardian. The only page that requires a doctor's signature is the Individualized Medical Orders on page 4, giving us permission to administer medicine, including over the counter medicine.

FAMILY AND CAMPER INFORMATION

Please complete all sections. It is important that we be able to contact you in the event of an emergency. We strongly urge you to share any pertinent information about your child if they have special needs. This allows us to advise you about our ability to meet your child's needs and greatly increases the probability that their experience at camp 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 we cannot reach you. Please make certain to check the box indicating whether or not you are authorizing the emergency contact to make decisions about your child's medical care in the event that you cannot be reached. If they are people who are likely to know your 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 your child. Also, please obtain your child's **immunization record and attach it to this form.**

MENINGITIS VACCINATION

Please read and check the appropriate box and **sign**.

DECLARATION

Please read and **sign** the declaration at the end of the form. Thank you.

Unirondack Medical Form 2014

CHECKLIST

☐ **Page 1** **Camper/Family Info and Emergency Contacts** ***(To Be Filled Out By Parent)***

☐ **Page 2** **Medical Conditions, Physician and Insurance Information** ***(To Be Filled Out By Parent)***

☐ **Page 3** **Signed Declaration** ***(To Be Filled Out and Signed By Parent)***

☐ **Page 4** **Medical Orders** **(Include details of prescription medications to be dispensed at camp)** ***(To Be Filled Out and Signed by Doctor)***

☐ **Copy of Insurance Card** **(Attached)**

☐ **Copy of Immunization Record** **(Attached)**

PLEASE INCLUDE THE COMPLETED FORM WITH YOUR REGISTRATION (NOTE: Page 4 can be sent separately by May 1 if more convenient)

Unirondack Medical Form 2014 (page 1)

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

CAMPER INFORMATION

Name: _____

DOB: _____ Age at Camp: _____ Sex: _____ Weight: _____

Registered for Session(s): _____

FAMILY INFORMATION

Parent/Guardian: _____ Relationship: _____

Home Phone: _____ Work: _____ Cell: _____

Address: _____

Parent/Guardian: _____ Relationship: _____

Home Phone: _____ Work: _____ Cell: _____

Address: _____

EMERGENCY CONTACTS

Name: _____Relationship: _____

Address: _____

Home Phone: _____ Work: _____ Cell: _____

☐ I authorize this person to make medical decisions on behalf of my child in the event that I cannot be reached.

Name: _____ Relationship: _____

Address: _____

Home Phone: _____ Work: _____ Cell: _____

☐ I authorize this person to make medical decisions on behalf of my child in the event that I cannot be reached.

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Camper Name_____

MEDICAL CONDITIONS, LIMITATIONS, ALLERGIES

Please answer YES or NO:

Asthma_____ Diabetes_____ Seizures _____ Bleeding/Clotting _____ Heart Disease _____

Please list any other Conditions, Limitations, or Medications your child takes:

_____
_____
_____

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 household.):*

_____
_____
_____
_____
_____
_____
_____

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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Camper Name_____

IMMUNIZATION RECORDS

Please attach a photocopy of your child's immunization records to this form.

The NYS Dept. of Health requires a complete record of all immunizations received prior to attending Unirondack. We require dates of the following Immunizations: **Tetanus, DPT, Polio, Measles, Mumps, Haemophilius Influenza type A and type B, Hepatitus B, Rubella** 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 campers complete and return the following certification. 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 will not obtain immunization against meningococcal meningitis disease.

Parent's Signature: _____**Date:** _____

DECLARATION

I, as parent/guardian of the above named UNIRONDACK camper, 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 this camper if I cannot be reached at the above emergency 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 will refuse to accept and will send home any camper who has a health, emotional, behavioral or physical needs that can not be handled safely or appropriately at Unirondack.

Name _____**Signed** _____**Date**_____

Unirondack Medical Form 2014 (page 4) Camper Name_____

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

Note: Form must be filled out and signed by Dr. even if there are no prescription medications. This form is required by New York State.

Please indicate by circling Yes or No whether the following medications can be administered to the camper at the discretion of the Camp's Medical Director. Without Dr. signature OTC medications cannot be administered.

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 camper 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**_____