PCYB Adventure Camp
REQUIRED MEDICAL HISTORY

(Parent or Legal Guardian to Complete)

DAY CAMPER – YOUTH BUREAU

Session (Please circle): July 12, 2016 ------- July 19, 2016 ------ July 26, 2016 ----- August 02, 2016

Camper Name _____ **Date of Birth:** _____
Address_____ **Phone#:** _____ _____
_____ _____

Emergency Notification:

With whom does child reside and what is / are his / her relationship(s) with the child? _____

Parent 1 Name_____ Phone: Home _____ Work _____ Cell _____
Parent 2 Name_____ Phone: Home _____ Work _____ Cell _____

Person to contact in an emergency if parents are unavailable:

Name: _____ Phone: Home_____ Work_____ Cell _____
Physician: _____Phone:_____ Fax: _____
Dentist/Orthodontist: _____ Phone_____

Emergency Medical Information (check yes or no)

Yes___ No___ Allergy to a medicine, food, plant, animal, or insect
Yes___ No___ Do you have an epinephrine pen?
Yes___ No___ Any condition that requires special care, medication or diet
Yes___ No___ Asthma
Yes___ No___ Contact Lenses
Yes___ No___ Seizure Disorder
Yes___ No___ Diabetes ____ Type 1____Type 2
Yes___ No___ Heart Trouble
Yes___ No___ Bleeding Disorder
Yes___ No___ Dentures
Yes___ No___ Bonded Teeth

Explain any of the above: _____

Medical History (check yes or no)	**Yes**	**No**	**Date**	**Details**
Serious illness	_____	_____	_____	_____
Serious injury	_____	_____	_____	_____

Does your child have frequent: (circle yes or no)
Y / N Respiratory Infections

Does your child have: (circle yes or no)
Y / N Heart Murmur **Y / N** Back or Joint Pains
Y / N Hernia **Y / N** Stomach/Intestinal Problems

Explain any of the above:_____

Has this person had Chicken Pox? ( ) Yes ( ) No If yes, when? Date_____
Has this person had Mumps? ( ) Yes ( ) No If yes, when? Date _____
Has this person been exposed to a **contagious disease** within the past three weeks? _____
Has this person had **lice** in the past six months? _____

Does this person take any medication (including prescription, over the counter medication, inhalers, epi-pen, etc.)? Yes* ___ No ____
Explain:_____

***IF YES, PAGE 2 OF THE MEDICAL EVALUATION FORM MUST BE COMPLETED BY THE DOCTOR OR THE CHILD CANNOT TAKE THEIR MEDICATION AT CAMP!**

To the best of my knowledge, the above information is correct. I give my child permission to participate in all camp activities.
In the event of accident or illness, I authorize the PCYB to institute and obtain medical care including but not limited to sutures, casts, any x-rays or CT scans requiring radiation. I also understand that I, the parent or guardian, is responsible for transport home of my camper due to illness or injury. In the event of a communicable disease outbreak, I understand this person will be excluded from camp if not fully immunized. I also understand that all medical forms must be complete and on file BEFORE my camper begins any of the above session(s).

DATE_____ **SIGNATURE (parent or legal guardian)**_____

Putnam County Youth Bureau
PCYB Adventure Camp

MEDICAL EVALUATION

(To be completed by physician)

Name_____Date of Birth_____

_____has had a complete history and physical exam on_____
Name Month/Day/Year

Screening / Test Results

Height:	**BMI:**	**Vision/Type of Screening**
Weight:	□ Normal	With Glasses R 20 / L 20 /
Blood Pressure:	□ Abnormal	With out Glasses R 20 / L 20 /
Pulse:	Min:	
HCT/Hgb:	Slight:	**Auditory /Type of Screening**
Urinalysis:	Mod:	Right Pass / Fail
Gross Dental:	Marked:	Left Pass / Fail
Lead (Date/Result):	□ Referral to:	

TB: In high-risk group? □ yes □ no		
TB & other Test Results: (Sickle Cell, etc.)		
Test	**Date**	**Result**

Disease Assessment

Yes	**No**			**Date of Onset**
□	□	Allergies	To What:	
□	□	Asthma	□ Mild □ Moderate □ Severe □ Exercise Induced □ Unclassified	
□	□	Diabetes	□ Type I □ Type II	
□	□	Anaphylactic Reaction	□ Food □ Insect □ Latex □ Other: Explain	
□	□	Seizure Disorder	Type:	
□	□	Chicken Pox	If yes, when?	
□	□	Mumps	If yes, when?	
□	□	Other: Please Specify		

Immunization History

(Please attach a current list of your child immunization records)

****If a child is on medication (including over-the-counter medicine, Epi-Pens, Inhalers, etc.) for ANY reason, the next two pages MUST be filled out by the physician. If it is not, the child WILL NOT BE GIVEN THEIR MEDICATION AT CAMP! ****

Child's Name: _____ **DOB**_____

Prescription Medication: Please complete with patient's current regimen for both scheduled and PRN medications; please use additional paper if needed. If child is diabetic, please include Doctor's orders on a separate page.

DRUG ROUTE DOSAGE FREQUENCY COMMENTS DIAGNOSIS

_____

_____

Emergency Medications:

Does this person require: **Epi-pen:** □ yes □ no **PRN Inhaler:** □ yes □ no

This person has permission to carry: **Epi-pen:** □ yes □ no **PRN Inhaler:** □ yes □ no

(Note: ability to carry implies ability to self administer)

Additional Orders: As deemed necessary by health care provider to be implemented by an R.N. (i.e. dressing changes, cast care, etc.):

_____

_____

Limitations on Activities:

Swimming_____ Hiking_____Athletics_____Other:_____

Explain above:_____

I certify that I have on this date examined the above named camper and that on the basis of my examination and the medical history as furnished to me, I have found no reason which would make it medically inadvisable for this camper to participate in physically strenuous activities.

Signature of Physican_____Date of Examination_____

Please Print: Physician's Name_____License# _____

Address_____ Phone#_____

Family Insurance Information: Please send a copy of both the front and back of all Health Insurance and Prescription Cards so they can be submitted at time of service to save you money.

Policy Holder_____ Carrier_____

Policy Number_____ Address_____

Does this policy include dental coverage? Yes_____ No_____

Sunscreen & Bug spray Permission: TO BE SIGNED BY PARENT

I give permission for PCYB & Camp Herrlich staff members to apply or aid in applying **sunscreen AND OR bug spray** to my child. **I will drop off sunscreen & bug spray to PCYB clearly labeled with my child's name**. I also certify that this product is FDA approved and that I have tested this product on my child with no adverse reactions. PCYB and Camp Herrlich will be held harmless for any reaction due to application of sunscreen I provide.

If you have sunscreen requirements or a schedule for application, please tell us here:

_____

Parents Signature: _____Date: _____

HIPPA Privacy Statement: Permission to Release Confidential Health Information

I give _____permission to release confidential health information to Camp Herrlich
Name of Medical Practice

regarding this person_____
Name of Camper or staff member

Date:_____ Parents/Guardian Signature:_____

Camper Name:_____ **Date of Birth:**_____

Standard Over the Counter Medications:

The following medications are available in the Health Center and will be administered at the discretion of the Health Director, PRN only with **Physician's Order** and **Parental Permission**. Please complete dosage and schedule for medications which can be given to participant.

Drug Name	Route	Dose	Schedule	Indications	Comments
Ibuprofen	PO	_____MG _____ML	Q_____HRS	Pain, fever, cold sx, toothache, muscle aches	
Acetaminophen	PO	_____MG _____ML	Q_____HRS	Pain, fever, cold sx, toothache, muscle aches	
Robitussen	PO	_____MG _____ML	Q_____HRS	Cough	
Cough Drops & Lozenges	PO	_____MG _____ML	Q_____HRS	Cough, sore throat	
Allergy tab: Claritin Diphenhydramine	PO	_____MG _____ML	Q_____HRS	Insect bites, allergies, respiratory allergies	
Loperamide – diarrhea Antacid	PO	_____MG _____ML	Q_____HRS	Gas, heartburn, indigestion, stomach	
Milk of Magnesia	PO	_____MG _____ML	Q_____HRS	Constipation	
Calamine, Caladryl, Hydrocortisone	PO	_____MG _____ML	Q_____HRS	Insect bites, rash, skin irritation	
Bacitracin, Neomycin, Polymycin	PO	_____MG _____ML	Q_____HRS	Cuts, scrapes	
Antifungal Cream, Spray	PO	_____MG _____ML	Q_____HRS	Athletes foot, jock itch	
Cooling Gel, Aloe	PO	_____MG _____ML	Q_____HRS	Burns, sunburn, wind burn	
Muscle Rub – Ben Gay, Tiger Balm	PO	_____MG _____ML	Q_____HRS	Minor muscle strains or pains	
Orasol, Ambesol, Abreva	PO	_____MG _____ML	Q_____HRS	Oral herpes, cold sores, toothache	
Visine	PO	_____MG _____ML	Q_____HRS	Eye Strain, Eye irritation	
Medicaine	PO	_____MG _____ML	Q_____HRS	Insect Stings	

Doctor's Signature:_____

Parental/Guardian Signature:_____