2018 JCC of Mid-Westchester Camps
Staff Medical Form

Return to Camp Office by June 1, 2018

Name ____ Birth date _____________ Age at camp _________
Last First Middle

Home address ____
Street Address City State Zip

Custodial parent/guardian ____ Phone _________________________

Home address ____
(if different from above) Street Address City State Zip

Business address ____Phone __________________
Street Address City State Zip

Second parent or guardian or emergency contact ____

Address ____Phone ___________________

Business address ____Phone ___________________

If not available in an emergency, notify:

Name ____

Relationship ____ Phone ___________________

Address ____
Street address City State Zip

Insurance Information

Is the participant covered by family medical/hospital insurance? ☐ Yes ☐ No

If so, indicate carrier or plan name ____ Group # __________________________

Carrier address ____

Name of insured ____ Relationship to participant _______________________

Social security number of policy holder or insurance ID number ____

Parent/Guardian Authorizations: This health history is correct and complete as far as I know. The person herein described has permission to engage in all camp activities except as noted. I hereby give permission to the camp to provide routine health care, administer prescribed medications and seek emergency medical treatment including ordering x-rays or routine tests. I agree to release any records necessary for insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for the person named above.

Signature of parent /guardian ____ Date ________________

Health History

The following must be filled in by the parent/guardian. The intent of this information is to provide camp health care personnel the background to provide appropriate care. Keep a copy of the completed form for your records. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp. Provide complete information so that the camp may be aware of your needs.

Allergies List all known.

Describe reaction and management of reaction.

Medication allergies (list)

_________________________________ ____
_________________________________ ____
_________________________________ ____
_________________________________ ____

Food allergies (list)

_________________________________ ____
_________________________________ ____
_________________________________ ____
_________________________________ ____

Other allergies (list) – include insect stings, hay fever, asthma, animal dander, etc.

_________________________________ ____
_________________________________ ____
_________________________________ ____
_________________________________ ____

Medications Being Taken

Please list all medications (including over-the-counter or nonprescription drugs) taken routinely. Keep the medication that you are bringing to camp in its original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage and the frequency of administration (**for Staff under the age of 18 years old**).

☐ This person takes NO medications on a routine basis.

☐ This person takes medications as follows:

Med #1 ___________________________________Dosage _________ Specific times taken each day ________________________________

Reason for taking ____

Med #2 ___________________________________ Dosage _________ Specific times taken each day _______________________________

Reason for taking ____

Med #3 ___________________________________ Dosage _________ Specific times taken each day _______________________________

Reason for taking ____

Attach any additional pages for more medications.
Identify any medications taken during the school year that participant does/may not take during the summer:
____

Restrictions

Explain any dietary restrictions.

____

____

Explain any restrictions to activities (e.g. what cannot be done, what adaptations or limitations are necessary)

____

General Questions

Has/does the participant	Yes	No		Yes	No
1. Had any recent injury, illness or infectious disease?	☐	☐	13. Ever had chest pain during or after exercise?	☐	☐
2. Have a chronic or recurring illness/condition?	☐	☐	14. Ever had high blood pressure?	☐	☐
3. Ever been hospitalized?	☐	☐	15. Ever been diagnosed with a heart murmur?	☐	☐
4. Ever had surgery?	☐	☐	16. Ever had back problems?	☐	☐
5. Have frequent headaches?	☐	☐	17. Ever had problems with joints (e.g., knees, ankles)?	☐	☐
6. Ever had a head injury?	☐	☐	18. Have an orthodontic appliance being brought to camp?	☐	☐
7. Ever been knocked unconscious?	☐	☐	19. Have any skin problems (e.g. itching, rash)?	☐	☐
8. Wear glasses, contacts or protective eye wear?	☐	☐	20. Have diabetes?	☐	☐
9. Ever had frequent ear infections?	☐	☐	21. Have asthma?	☐	☐
10. Ever passed out during or after exercise?	☐	☐	22. Had mononucleosis in the past 12 months?	☐	☐
11. Ever been dizzy during or after exercise?	☐	☐	23. Had problems with diarrhea/constipation?	☐	☐
12. Ever had seizures?	☐	☐	24 Ever had emotional difficulties for which professional help was sought?	☐	☐

Please explain any “yes” answers, noting the number of the question you are referring to.

____

____

____

____

Which of the following has the participant had?

☐ Measles
☐ Chicken Pox
☐ German measles
☐ Mumps
☐ Hepatitis A
☐ Hepatitis B
☐ Hepatitis C

TB Mantoux Test
Date of last test ______________________
Result: ☐ Positive ☐ Negative

Please give all dates of immunization for:

Vaccine: Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP	______	______	______	______	_____	_____
TD (tetanus/diptheria)	______	______	______	______	_____	_____
Tetanus	______	______	______	______	_____	_____
Polio	______	______	______	______	_____	
MMR	______	______				
or Measles	______	______				
or Mumps	______	______				
or Rubella	______	______				
Haemophilus influenza B	______	______	______	______		
Hepatitis B	______	______	______			
Varicella (chicken pox)	______	______				

Use this space to provide any additional information about the participant’s behavior and physical, emotional or mental health about which the camp should be aware.

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____

____

Name of family physician ____ Phone ___________________________

Address ____

Name of family dentist/orthodontist ____ Phone ___________________________

Address ____

Health Care Recommendations by Licensed Medical Personnel

Date of Examination ______________________________________

Height	__________________	Weight	________________	Lead level	___________________
Eyes	__________________	BP	________________	Scoliosis	___________________
Glasses	__________________	Heart	________________	Allergies	___________________
Ears	__________________	Lungs	________________	Teeth	___________________
Abdomen	__________________	General health	________________		

In my opinion, the above applicant ☐ is ☐ is not able to participate in an active camp program.

The applicant is under the care of a physician for the following conditions:

____

____

Recommendations and Restrictions at Camp

Medications to be administered at camp

____

____

Any medically prescribed dietary restrictions

____

____

Known allergies

____

____

Description of any limitation or restriction on camp activities

____

____

Additional information for health care staff at camp

____

____

I have examined the child herein described and have reviewed his/her health history. It is my opinion that he/she is physically able to engage in all camp activities, except as noted.

____ ____

Examining physician's signature Physician's printed name

____

Street address City State Zip

____ ____

Phone Date completed

JCC of Mid-Westchester Camps 2018
Medication Procedures

Dear Parent/Guardian:
It is possible for you to have your child given both non-prescription and prescription medications, if needed. Please follow these guidelines.

I. Acetaminophen (Tylenol) and Benadryl Only
The medications that are available are acetaminophen (i.e. Tylenol, etc.) for fever or pain, and diphenhydramine hydrochloride (i.e. Benadryl, etc.) oral liquid for allergic reaction or itching. These medications will be given after you have been contacted in order to prevent medication duplication. In the unlikely event of a severe allergic reaction, Benadryl may be given with only your written permission. Even though we will call you before administering these medications, we are required to have it in writing in advance. If you wish to give permission for these medications, please complete the attached Non-Prescription Medication Permission Form and have your child's physician sign this form. Please return it to our office once you have both signatures but no later than June 1.

II. Prescription Medication(s) and Other Non-Prescription Medication(s)
If your child has an illness that is being treated with either a prescription or a non-prescription medication the camp nurse or designee can administer it, if needed, during camp hours. In order to comply with Health Department regulations, please do the following if you need us to give medication to your child.

A. Contact the camp nurse to obtain necessary form and instructions.

B. Ask your physician for a written order for any medication, either prescription or non-prescription that your child needs to take during camp hours. In addition, ask the physician to write down any restrictions for your child while your child is taking the medication. Remember, if your child is placed on a medication, ask the physician when he puts the child on any medication, to write you a note for the school to dispense the medication, if your child needs it during the camp hours, which includes the dates and times for the medication to be given. Give the physician's note to the camp nurse with the medication.

C. In addition, you must sign an administration of medication form giving the camp nurse your permission to give your child the medication.

D. You must send the medication in the original container you received it in from the pharmacy or store. When you have a prescription filled, ask the pharmacist to put it into two containers - one for those doses to be given during the camp time and the other for those taken at home. On the container for prescription medications must be the child's name, medication name, dosage of medication, how the medication is to be given and frequency of administration. Containers saying administer as directed cannot be used by the camp nurse. On the containers of non-prescription medications, please write your child's name. All medications will be kept locked in the health office.

E. If possible, please bring the medication to the camp when it is the first time it is to be given. DO NOT SEND MEDICATION IN YOUR CHILD'S BAG. This is for the safety of all the children.
If you can't bring it please give it to the adult who is bringing your child to camp that day and ask them to bring the medication to the camp nurse.

The above guidelines are those required for the safe administration of medications to your child. It is in your child's best interest that you follow them. If you have any questions, please call 472-3300. Extensions for camps are below.

Yours truly,

______________________	____________________	________________
Tobe Sevush x346	Jayne Santoro x320	Caryn Symons X336
Director, Summer Arts Center	Director, Dance Intensive	Director, Gadol/CIT-LIT

<u>Non-Prescription Medication Permission Slip</u> **<u>(Under 18 years of age)</u>**

Please sign your name and have your child's physician sign for the medication(s) you want to have administered, if needed, to your child by the camp nurse. In most instances, the medication will not be given to your child until after you have been called and given your verbal permission. However, in the case of an allergic reaction, the camp will make every effort to contact you, but will administer Benadryl if it is necessary as long as you and your child's physician have signed this form.

Child's Name: ____________________________Age:_____________ Weight:___________

Address: ____Zip:______________

I give permission to the camp nurse to administer the following medication(s), if needed, according to the dosage listed, to my child as named above:

1. Acetaminophen (I.E. Tylenol, etc.), dosage listed below, every 4-6 hours as needed for pain or fever:

Ages 12 and over (over 100 lbs.) 380-650 mg. PO

_______________________________ _______________________________
Parent's/Guardian's Signature Physician's Signature

_______________________________ _______________________________
Parent's/Guardian's Printed Name Physician's Printed Name

_______________________________ _______________________________
Date Physician's Reg. #

2. Diphenhydramine Hydrochloride (Benadryl) 12.5-25 mg. PO for allergic reaction.

_______________________________ _______________________________
Parent's/Guardian's Signature Physician's Signature

_______________________________ _______________________________
Parent's/Guardian's Printed Name Physician's Printed Name

_______________________________ _______________________________
Date Physician's Reg. #

Topical Medications that may be administered with parent/guardian **and** physician written permission to your child when at camp are listed below. Please note that written permission for use of these medications is an updated New York State policy as of 2011. We need both you, as your child's parent/guardian **and** your child's physician to sign for each topical medication.

1. **Bacitracin Ointment**

_______________________________	_______________________________
Parent's/Guardian's Signature	Physician's Signature
_______________________________	_______________________________
Parent's/Guardian's Printed Name	Physician's Printed Name
_______________________________	_______________________________
Date	Physician's Reg. #

2. **Hydrocortisone Cream 0.5%**

_______________________________	_______________________________
Parent's/Guardian's Signature	Physician's Signature
_______________________________	_______________________________
Parent's/Guardian's Printed Name	Physician's Printed Name
_______________________________	_______________________________
Date	Physician's Reg. #

3. **Calamine Lotion**

_______________________________	_______________________________
Parent's/Guardian's Signature	Physician's Signature
_______________________________	_______________________________
Parent's/Guardian's Printed Name	Physician's Printed Name
_______________________________	_______________________________
Date	Physician's Reg. #

<u>Administration of Prescribed Medication</u> **<u>(Under 18 years of age)</u>**

The camp has developed a policy regarding the administration of medications which is consistent with New York State guidelines, accepted medical practice and children's safety. Students are not to carry any medication for self-administration **MEDICATION MUST BE DELIVERED TO THE CAMP AND TAKEN HOME BY A PARENT OR GUARDIAN ONLY. THERE WILL BE NO EXCEPTIONS.**

Thank you for your cooperation.

<u>TO BE COMPLETED BY THE PARENT/GUARDIAN:</u>

I hereby request that the camp nurse (or Director's designee) administer medication as prescribed by my child's physician.

Student's Name ___________________________Date of Birth_______________

Parent/Guardian daytime telephone number______________________________

I hereby release the employees of the JCC of Mid-Westchester from any and all liability arising from the administration of this medication.

Date_____________ Parent/Guardian Signature___________________________

Patient_______________________ Diagnosis_____________________________

Medication ___________________ Dose__________ Frequency_____________

Dates for Administration: From_________________ Through_______________

If PRN, signs and symptoms for administering medication___________________

____

Possible Side Effects____

Restrictions(what and how long?)_______________________________________

M.D. Name (**PRINT**)______________________________Tel. #_______________

Address____Zip_____________

N.Y.S. Reg. #_______________________________

Date________________ M.D. Signature_________________________________

IMPORTANT: Prescription medication must be in a **PRESCRIPTION BOTTLE** with a proper Pharmacist's label attached. Medication containers stating "give as directed" **CANNOT** be used by the JCC of Mid-Westchester. The label must list the student's name, medication, dosage, directions for use and the physician's name.