Salesian Camp Echo Bay
Medical and Emergency Form

This information on this form is gathered to assist us in identifying appropriate care for the camper.

The parent or guardian of the camper can fill out this form **EXCEPT FOR** the **"Health History and Recommendations of a Licensed Medical Person."**

If there is an order of protection or visitation order for the camper please submit a copy with this form.

This form **MUST** be on file in the camp Health Office **BEFORE** your child begins camp in order for your child to participate.

Medical and Emergency Form

Camper's Name:_____

Date of Birth: _____ Age of Camper:_____

Gender of Camper: (m) (f)

Home Address:_____

_____

Home Phone Number: (_____)_____

Name of Custodial Parent or Guardian:_____

Mother or Guardians Work Number: (_____)_____

Beeper Number: (_____)_____

Cell Phone Number: (_____)_____

Father or Guardians Work Number: (_____)_____

Beeper Number: (_____)_____

Cell Phone Number: (_____)_____

Emergency Phone Numbers

1. Name:_____

Phone Number: (_____)_____

Relationship to Camper:_____

2. Name: _____

Phone Number: (_____)_____

Relationship to Camper:_____

Doctor's Name:_____

Doctor's Phone Number: (_____)_____

Hospital Release and Parent Authorization

I give permission, in case of injury to take my child _____, to the hospital for treatment, to include evaluation of injuries, x-rays, and emergency care.

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

Hospitalization Insurance Company:_____

Identification Number:_____

The New York State Health Department must have this completed and returned to the Health Office **BEFORE** the child begins camp.

Thank You

Medication Being Taken

List all medication, prescription and non-prescription drugs routinely taken: ___

_____

_____

_____

_____

If the camper takes no medication on a routine basis, check here: ( )

Authorization for administration of medication at camp; prescription and non-prescription:

I request that my child, _____receive the medication as prescribed in the following section by our Licensed Medical Professional. The medication is to be furnished by me in a properly labeled original container with child's name.

I understand the Camp Nurse or other assigned person will administer the medication.

Parent Signature:_____

Date: ____/____/____

THE FOLLOWING IS COMPLETED BY A LICENSED MEDICAL PROFESSIONAL. SIGNATURE AND STAMP REQUIRED.

Health History

1. **List all known allergies or medical problems.**
   Describe reaction and management of the reaction or care for medical problem._____
   _____
   _____
   _____
   _____

2. **List all food allergies:**_____
   _____
   _____
   _____

3. **All other allergies: Include insect stings, hay fever, asthma, reactive airway, disease, etc:**_____
   _____
   _____
   _____

I request that my patient, as listed below, receive the following medication:

Name of Camper: _____ Date of Birth: ____/____/____

Diagnosis:_____

Name of Medication: _____

Prescribed dosage, frequency and route of administration: _____

_____

Time to be taken at camp: _____ (am) (pm)

Duration of treatment: _____

Possible side effects and adverse reactions (if any):_____

_____

Other Recommendations: _____

_____

Any restrictions to activity at camp: _____

_____

_____

IMMUNIZATIONS

Give all dates, include month, date, year, series complete, fully immunized, up to date, not accepted by the Health Department.

DPT/TD: __/__/__/ __/__/__/ __/__/__/ __/__/__/ __/__/__/

Polio: __/__/__/ __/__/__/ __/__/__/ __/__/__/

MMR #1: __/__/__/ **MMR #2:** __/__/__/
OR:
Measles: __/__/__/ **Mumps:** __/__/__/

Haemophilas Influenza (HiB): __/__/__/ __/__/__/ __/__/__/

Hepatitis B: __/__/__/ __/__/__/ __/__/__/

Varicella: __/__/__/

TB Mantoux date of last test: __/__/__/

A) Results ( ) Positive ( ) Negative

B) Chest x-ray results if test positive: _____

C) Medication: _____

Use this space to provide and additional information about the participant's behavior, physical, emotional or mental health about which the camp should be aware (ADD, ADHD, Diabetic, etc.)_____
_____
_____
_____

Signature of Licensed Medical Professional: _____

Professional's Name & Title (Print Please)**:** _____

Date: _____/_____/_____

Address: _____

_____

Phone: (_____)_____

(Stamp to be used along with signature and date)