SURPRISE LAKE CAMP STAFF 2008

Winter Address:
307 Seventh Avenue, Suite 900, New York, NY 10001
Phone: 212-924-3131 FAX: 212-924-5112

Summer Address (June 15 – August 31):
Cold Spring, NY 10516
Phone: 845-265-3616 FAX: 845-265-3646

Attach your photo here.

*** * * * IMPORTANT * * * ***
Copies (both sides) of your medical insurance card and prescription card must be attached here.

REQUIRED MEDICAL INFORMATION (PARENT OR LEGAL GUARDIAN TO COMPLETE if staff is under 18):

Name_____ **Date of Birth**_____
Address_____
_____
Phone _____

PLEASE CHECK ONE:
( ) **Returning Staff**
( ) **New Staff**

Session_____

EMERGENCY NOTIFICATION:
With whom does staff reside and what is/are his/her relationship(s)?_____
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:_____ Home Phone: _____ Work Phone: _____
Physician_____Phone_____
Dentist/Orthodontist_____Phone_____

EMERGENCY MEDICAL INFORMATION (check one)**:**

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**___ Psychiatric/Psychological
Yes___ **No**___ Seizure Disorder
Yes___ **No**___ **Diabetes**
Yes___ **No**___ Heart Trouble
Yes___ **No**___ Bleeding Disorder
Yes___ **No**___ Dentures
Yes___ **No**___ Bonded Teeth

Explain any of the above:_____
_____

MEDICAL HISTORY (check one)**:**

	Yes	No	Date	Details
Serious illness	_____	_____	_____	_____
Serious injury	_____	_____	_____	_____
Surgery	_____	_____	_____	_____

Do you have frequent: (circle one)
Y/N Eye Infections **Y/N** Respiratory Infections
Y/N Ear Infections **Y/N** Urinary Tract Infections
Y/N Throat Infections **Y/N** Vaginal Infections

Do you have: (circle one)
Y/N Heart Murmur **Y/N** Menstrual Problems
Y/N Rheumatic Fever **Y/N** Hernia
Y/N Stomach/Intestinal Problems **Y/N** Back or Joint Pains

Explain any of the above:_____
Have you had Chicken Pox? _____ Date_____
Have you been exposed to a contagious disease within the past three weeks? _____
Have you had lice in the past six months? _____
Do you take any medication on a regular basis during the year? yes_____ no_____
Explain:_____

FAMILY INSURANCE INFORMATION: Surprise Lake Camp provides in camp nursing and doctor care and over the counter medications at no charge. All bills for out of camp physician's care, dental care, hospital visits, laboratory tests, x-rays, and prescription medications will be sent directly to the family for submission to its insurance plan. Camp will charge the family for any medication ordered by the family physician that we do not stock. **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 SERVICES TO SAVE YOU MONEY.**

Policy Holder_____ Carrier_____
Policy Number_____ Address_____
Does this policy include dental coverage? Yes_____ No_____

To the best of my knowledge, the above information is correct. I give my child permission to participate in all camp activities and trips. In the event of accident or illness, I authorize Surprise Lake Camp to institute and obtain medical care.

DATE_____SIGNATURE (parent or legal guardian if staff is under 18 years of age)_____

PHYSICIAN TO COMPLETE OTHER SIDE OF FORM

MEDICAL EVALUATION (DOCTOR TO COMPLETE):

Name_____Date of Birth_____ has had a complete history and physical exam on_____
Month/Day/Year Month/Day/Year

SCREENING/TEST RESULTS

Height:	BMI – Postural:
Weight:	❑ Normal
Blood Pressure:	❑ Abnormal
Pulse:	Min._____
HCT/HGB:	Slight_____
Urinalysis:	Mod._____
Gross Dental:	Marked_____
Lead (Date/Result):	❑ Referral

TB and Other Test Results (Sickle Cell, etc.):
TB: In high-risk group? ❑ Yes ❑ No

Test	Date	Results

Vision/Type of Screening:			Auditory/Type of Screening:
With glasses	**R 20/**	**L 20/**	**R Pass/Fail**
Without glasses	**R 20/**	**L 20/**	**L Pass/Fail**

Chronic Disease Assessment:

Yes	No		Date of onset
❑	❑	Asthma: ❑ mild ❑ moderate ❑ severe	_____
		❑ exercise induced ❑ unclassified	_____
❑	❑	Diabetes: ❑ Type I ❑ Type II	_____
❑	❑	Anaphylactic Reaction: ❑ food ❑ insect ❑ latex	_____
❑	❑	Seizure Disorder	_____
❑	❑	Other: Please specify_____	_____

IMMUNIZATION RECORD (Vaccine—Month/Day/Year)

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DTP						
DTP/Hib						
DTaP						
DT/Td						
OBV						
IPV						
MMR						
Measles						
Mumps						
Rubella						
HIB						
Heb B						
Varicella						
PCV						

Other Vaccines (Specify)

Disease Hx of above_____ _____ _____
(Specify) (Date) (Confirmed by)

Exemption

Religious_____ Medical: Permanent_____Temporary_____Date_____

Recertify Date_____ Recertify Date_____ Recertify Date_____

The following Standard Over the Counter/PRN Medications are available in the Health Center to be administered if needed per the family physician's instructions.

*** * * THIS SECTION MUST BE COMPLETED IF UNDER 18 YEARS OF AGE * * ***

MEDICATION	DOSAGE/SCHEDULE	AGREE WITH ORDER YES	/ NO	COMMENTS
Pain reliever/fever reducer:				
Acetaminophen/Ibuprofen	per label instructions by age/weight	❑	❑	_____
Auralgan Drops for ear pain	per label instructions by age/weight	❑	❑	_____
Claritin/Diphenhydramine for allergy symptoms	per label instructions by age/weight	❑	❑	_____
Cough Suppressants	per label instructions by age/weight	❑	❑	_____
Abdominal discomfort:				
Milk of Magnesia/Antacids/Kaopectate	per label instructions by age/weight	❑	❑	_____
Dramamine for motion sickness	per label instructions by age/weight	❑	❑	_____
Decongestants	per label instructions by age/weight	❑	❑	_____
Sore throat: Lozenges/Chloraseptic	per label instructions	❑	❑	_____
Eye irritation: Naphcon A/Visine AC	per label instructions	❑	❑	_____
Skin irritation: Epsom Salt	per label instructions	❑	❑	_____
Topical Antibiotics:				
Bacitracin/Neosporin/Bactroban	per label instructions	❑	❑	_____
Topical Antipruritics:				
Calagel/Hydrocortisone	per label instructions	❑	❑	_____

PRESCRIPTION MEDICATIONS: Please complete with patient's current regimen for both scheduled and PRN medications including heparin flushes for central lines; please use additional paper if needed. PILL MEDICATIONS MUST BE ORDERED AND PACKAGED IN ADVANCE THROUGH WHITE'S HEALTHCAREfor Staff members under 18 years of age. – see separate letter.

DRUG ROUTE DOSAGE SCHEDULE COMMENTS

_____

_____

ADDITIONAL ORDERS: As deemed necessary by health care provider to be implemented by an R.N. (i.e. peak flows, blood draws/lab work, dressing changes, cast care, feeds via GT, etc.):_____

_____

LIMITATIONS ON ACTIVITY: Swimming_____Diving_____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_____Date of Examination_____

Please Print: Physician's Name_____License #_____

Address_____ Phone#_____

Sheryl/staff medical 2008