

Dear Parent/Guardian,

To attend Ramapo this coming summer, your child is required by law to have a fully completed **Health History Form** including a recent **Medical Exam** (per NYS law, the exam date must be within one year of your child's last day at camp) and an up-to-date **Immunization Record**. Please ensure that all sections are complete and that you **and** the physician sign where appropriate.

Your child's application will not be processed until the attached form is accurately completed.

Camp Ramapo provides an excellent health center should your child require medical care. The center is staffed by licensed nurses; emergency medical technicians and a part-time pediatrician. Included in the camp fee are all visits to the camp health center and over-the-counter medications. Any illness or accident which requires a visit to a physician or hospital in the community will be charged to the parent. All prescription medications dispensed at a registered pharmacy will be charged to the parent as well. **Therefore it is required that you attach a copy of your child's health coverage card to the Health History and Exam Form.**

If you have any questions or need assistance, please don't hesitate to give us a call. We look forward to a happy summer of growth for all of our campers.

Sincerely,

Mike Kunin
Camp Director

CAMP RAMAPO
P.O. BOX 266/RHINEBECK, NY 12572
(845)876-8403

CAMPER HEALTH HISTORY AND EXAMINATION

This form is due at the time of application. The information on this form is not part of the camper acceptance process, but is gathered to assist us in identifying appropriate care. **This form**, except for the "Health Recommendations of Licensed Medical Personnel (Page 4)," **is to be completely filled in by the parent or guardian.** **Be sure to put camper name on each page of this form.**

Camper's Name _____ Birth date _____ Age at
camp _____
Last Name First Name Middle

Home
address _____
Street address Apt # City State Zip

Gender: Male Female

Custodial Parent/Guardian _____ Phone _____

Cell Phone _____

Business Address _____
Phone _____

Second parent/ guardian or emergency contact
_____ Phone _____

Home address _____
Street address Apt # City State Zip

Business Address _____
Phone _____

Area Code Phone Number

Professional Contact (Psychologist, Social Worker, Case Manager, etc.) _____

Work Phone _____ Home Phone _____ Cell Phone _____
Area Code Phone Number Area Code Phone Number Area Code Phone Number

MEDICAL INSURANCE

If you have no medical insurance, write **NONE**: _____

IMPORTANT: You MUST attach a copy of BOTH sides of the camper's Insurance (or Medicaid) card.

Insurance _____ carrier _____ or _____ plan
name _____

Insurance _____ ID _____ / _____ Medicaid _____ number _____

Name _____ of _____ insured _____ / _____ policy _____ holder _____

Relationship to participant _____ Social security number of policy holder _____

Please note: Parent/guardian will be responsible and billed for all costs of medical and dental treatment

Important – This box must be complete for attendance

This health history is correct so far as I know: The person herein described has permission to engage in all

prescribed camp activities except as noted by me and the examining physician.

Permission to Provide Necessary Treatment or Emergency Care: I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for the person named above. ***I will be responsible for the cost of all medical and dental treatment provided to my child while at camp.***

This completed form may be photocopied for trips out of camp.

Signature of parent or guardian

X _____ **Date** _____

Camper's Name _____

Health History

The following information 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 care personnel upon participant's arrival in camp. Provide complete information so that camp can be aware of needs. **DO NOT LEAVE ANY SPACES BLANK;** if not applicable to this camper, indicate with "N/A" or "not applicable".

ALLERGIES: List all known. Attach additional pages if necessary.

Medication allergies (list)

Describe reaction and management of the reaction.

Food allergies (list)

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

MEDICATIONS BEING TAKEN Please check appropriate box.

This applicant takes NO medications/ NO over-the-counter products on a routine basis.

Please list ALL medications taken routinely. Upon **acceptance and registration** into the camp program, you will receive specific guidelines regarding camp's medication policies and procedures. However, please note all medications and over-the-counter products to be administered during a camp stay will have to be accompanied by a written prescription. **DO NOT SEND WRITTEN PRESCRIPTIONS PRIOR TO ACCEPTANCE!**

This person takes the following medications:
Med #1 _____
Med #2 _____
Med #3 _____

Reasons:

Attach additional pages for more medications

Please be advised, we do NOT require campers to receive this vaccination. However, we ask you to inform the parents of the risks associated with Meningitis.

Please complete and sign the attached non-prescription / OTC form for this camper.

Signature of Licensed Medical Personnel

X _____ Date _____
Printed Name _____ Title _____
Address _____
Phone _____ Fax _____

For camp use only

Screening Record

Date screened _____ Time _____
Meds received _____
Updates/additions to health history noted? Yes No None required
Current health needs identified _____
Observational notes _____
Screened by _____

Over the Counter Medication Form Camp Ramapo Summer 2005

Camper's Name: _____ Birth date: _____ Session _____

Problem/Symptoms	Medication	Dosage	Healthcare Provider Orders
Temperature [$>100^{\circ}\text{F}$] Headache, minor aches and pains	Acetaminophen 325 mg tablets	Under age 12: 325mg PO q4h PRN Age 12 or older: 650 mg PO q4h PRN	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Acetaminophen Chewable 80 mg	Age 6-8 years: 320 mg PO q4h PRN Age 9-10 years: 400 mg PO q4h PRN Age 11 years: 480 mg PO q4hr PRN Age 12 years or over: 640 mg PO q4hr PRN	Yes <input type="checkbox"/> No <input type="checkbox"/>
Injury with swelling, toothache, Menstrual Pains	Ibuprofen 200 mg tablets or caplets	Age 6-12 years: 200 mg tablet q4h PRN Age 12 or older: 400 mg PO q4h PRN	Yes <input type="checkbox"/> No <input type="checkbox"/>
Chest Congestion (to loosen bronchial secretions)	Guaifensin/Guaitus 5cc=100mg	Age 6-11 years: 100mg (5cc) q4h PRN Age 12 and older: 200(10cc) mg PO q4h PRN	Yes <input type="checkbox"/> No <input type="checkbox"/>
Nasal/sinus congestion due to colds or allergies	Pseudo ephedrine HCL 30 mg tablets/caplet	Age 6-11: 30 Mg PO q4h PRN Age 12 and older: 60 mg PO q4h PRN	Yes <input type="checkbox"/> No <input type="checkbox"/>
Cold Symptoms: nasal congestion and cough due to minor throat and bronchial irritation	Children's Dimetapp	Age 2-6 years: 1 teaspoon q6h Age 6-12 years: 2 teaspoons q6h Age 12 and older: 4 teaspoons q6h (No more than 4 doses in 24 hours)	Yes <input type="checkbox"/> No <input type="checkbox"/>
Allergic symptoms: hives, rash, poison ivy/oak, swelling and itching from bee/wasp bites	Diphenhydramine	>20 lbs. 12.5mg >60 lbs. 12.5/25mg >110lbs. 25/50mg	Yes <input type="checkbox"/> No <input type="checkbox"/>
Hay Fever other upper respiratory allergies: runny nose; itchy, watery eyes; sneezing; itching of the nose or throat.	Loratadine 10 mg Tablets	Adults and children 6 years and over: 1 tablet daily; not more than 1 tablet in 24 hours	Yes <input type="checkbox"/> No <input type="checkbox"/>
Diarrhea, upset stomach, nausea	Bismuth	Age 3-6 years: 1/3 tab or 5ml/dose Age 6-9 years: 2/3 tab or 10ml/dose Age 9-12 years: 1 tab or 15ml/dose Adult: 2 tab or 30ml/dose	Yes <input type="checkbox"/> No <input type="checkbox"/>
Diarrhea, loose stool	Loperamide Hydrochloride caplets/capsules	Age 9-11 years: Initial dose 1 cap. Followed as needed by 1 cap. After subsequent loose stool not to exceed 6 caps. In 24 hours Age 12 or older : Initial dose, 2 caplets/capsules followed as needed by 1 cap. after each unformed stool not to exceed 8 caps. in 24 hours	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Loperamide Hydrochloride oral solution 5cc=1mg	Age 9-11 years: Initial dose 2 mg(10cc) PO, subsequent dose, 1mg (5cc) PO after each loose stool, not to exceed 6 mg (30cc) in 24 hours Age 12 or older : Initial dose, 4 mg (20cc) PO and 2mg (10cc) PO after each loose stool, not to exceed 8 mg (40cc) in 24 hours	Yes <input type="checkbox"/> No <input type="checkbox"/>
Constipation: camper reports stools are hard and dry or report inability to move bowels x 2 days.	Milk of Magnesia	In absence of acute symptoms (abdominal pain and/or vomiting w/ elevated temp.) administer: Age 6-12 years: 15cc hs followed by 8 oz. water Age over 12 years: 30cc hs followed by 8 oz. of water	Yes <input type="checkbox"/> No <input type="checkbox"/>
Upset stomach: acid indigestion, heartburn, sour stomach	Antacid	Under age 12: 10cc PO PRN up to 4 times a day Age 12 or older: 20cc PO PRN up to 4 times a day	Yes <input type="checkbox"/> No <input type="checkbox"/>

Physician Name (please print): _____

Physician Signature: _____

Date: _____

Physician Phone: _____