Camp Hollis Medical Form

Please return completed form to: Oswego City-County Youth Bureau, 70 Bunner St, Oswego NY 13126

Camper's Name _____ M ____ F _____ Home Phone # _____
DOB _____ Dates Attending Camp _____
Attended Camp Hollis last year? Yes _____ No _____ _____

Section A: Health History → to be completed by parent/guardian.

***Please attach Immunization Record and latest physical to this form.** (You can obtain a copy from your doctor's office/ school nurse.)

In the last few years has the child ever had: (Circle Yes or No)		
Hay fever: Yes No	Frequent ear infection: Yes No	Severe reaction to poison ivy: Yes No
Asthma: Yes No	Convulsions/seizures: Yes No	Diabetes: Yes No
Bed Wetting: Yes No (If "Yes" are pullups used? Yes No		Bleeding/Clotting Disorder: Yes No

Drug Allergies: _____
Severe reaction to insect or bee stings: Yes No If "Yes", is medication provided? _____
Reaction: _____

Food Allergies: Yes No If "Yes", to what food(s)? (You may be advised to discuss specific food needs with the kitchen staff)
_____
Reaction: _____

***If child is prescribed an EPIPEN or another emergency medication, it must be provided, or camper will not be allowed to stay.**

Any recent surgery or injuries? Yes No If yes please describe: _____
_____

***Diabetic campers or campers requiring specific medical equipment must bring them to camp and meet with nurse to go over use and management. Specific parameters of treatment must be written out including course of action. If diabetic, written instructions must be provided as to what action is to be taken if Blood Glucose is above a specific level or below a specific level, times to check glucose levels, and specific diet with food exchanges calculated. Campers must bring snacks/drinks to take if needed. Parent or guardian will be required to be available to contact with any equipment issues or need to add medication or change tubing. Camper must be knowledgeable regarding their own care.**

***Please note any special circumstances, restricted activities, emotional/behavioral problems, or recurring illness you feel we should be aware of (attach additional paper if needed):**
_____

***The Health History is correct to my knowledge. The person herein described has permission to engage in all prescribed camp activities except as noted.**
All campers will be required to have a head check prior to admittance at sign in. Camp Hollis/Oswego County has a *No Nit Policy
***All campers will be required to have a completed medical form and any medications or treatments including any over the counter medicines listed including name, dosage and instructions and signed by the physician to be able to attend camp. All medicines (including over the counter) must be in the original container labeled with child's name, medication, dosage and instructions.**
***Please send in 7 days of medication and if necessary split any pills in advance.**
***It may be deemed necessary to request you to pick up your child to go home for the safety and well-being of your child, and/or other campers and staff which will require you to arrive within two hours to take the camper home.**
*** Signature gives us permission to allow your child to be under the care and guidance of Camp Hollis/Oswego County and acknowledges agreement to all requirements.**

***Release of Information**

I authorize Oswego County/Camp Hollis to obtain information such as physical forms, immunization records and medication prescriptions for camp record requirement and retention. This information may be obtained by mail, phone and/or electronic transmission. Information about the camper's care, medical history and/or medication may be obtained from
*_____ **and released to CAMP HOLLIS/Oswego County.**

*** (Physician's Office and Phone Number Required)**

_____ _____ _____
→ **Parent/Guardian Signature** Address **Emer. Phone #**

**** Verification of emergency contact and phone at check in. Date:** _____

Camper Name: _____ **DOB:** _____ **Effective Date:** _____

****ALLERGIES**: _____
****MEDICAL CONDITIONS**: _____

Section B: Prescribed Medications/Treatments
****Any changes prior to attending camp will require written instructions signed by MD, PA or NP**

***NOTE: This section must be completed and signed by a Doctor, Physician's Assistant or Nurse Practitioner.**
PARENTS: WITHOUT THIS SIGNED DOCUMENT, THE HEALTH CENTER AT CAMP HOLLIS CANNOT SUPERVISE YOUR CHILD'S SELF-ADMINISTERING MEDICATIONS (AS APPROVED BY OSWEGO COUNTY HEALTH DEPT).

ORDERS FOR MEDICATIONS/TREATMENTS INCLUDING ANY ROUTINE OVER THE COUNTER MEDICATIONS:

Prescribed and Routine OTC*Medication/Dose	Route	Time of Day	Frequency	Reason

* **ALL MEDICATIONS MUST BE IN THE ORIGINAL CONTAINER PROPERLY LABELED***

Specific PRN Medications/Treatments: _____

_____

****DIABETICS: Child knowledgeable regarding diet/care_____ Snacks/Drinks as needed_____**

Pump_____

Medication/Dosage prescribed: _____

Blood Glucose Monitoring specific times:

_____ _____

If Blood Glucose is above _____ then (instructions): _____

If Blood Glucose is below _____ then (instructions): _____

Diet: _____

Coverage as instructed: _____

_____

***

_____ _____

→ ** **Physician/Nurse Practitioner Signature** ** **Date** **Physician's Phone Number**

***NOTE: Section C must be completed and signed by a Doctor, Physician's Assistant or Nurse Practitioner for administering any "Over the Counter" Medications/ Treatments available at the Camp Health Center to be given as needed (Attached)**

Camper Name: _____ **DOB:** _____ **Effective Date:** _____

Section C: Over the Counter Medications/Treatments available in the Health Center as Needed

NOTE: This section must be completed and signed by a Doctor, Physician's Assistant or Nurse Practitioner

PARENTS: Please note that without this document the Health Center at Camp Hollis cannot supervise your child's self-administering any over-the-counter medications and/or provide over-the-counter medications PRN (PRN = as needed).

INDIVIDUALIZED STANDING ORDERS;

These medications are available in our Health Center, and are to be dispensed following the site's Medical Guidelines. They are approved by Oswego Hospital Emergency Room Physician. Generic forms of the drugs may be used.

1. Mark an "X" to the left of any medications you wish your child/patient to receive if needed.
2. **Please provide signatures of both the camper's Parent/Guardian and Physician/Nurse Practitioner at the bottom of the page.**
   Medications will not be given without written physician orders.
3. **Over the counter medications provided by camper's family must be in the original container, properly labeled.**

___ **Acetaminophen:** Per label instructions by age/weight, every 4 hours as needed for headache, fever musculoskeletal complaints, menstrual cramps, minor pain

___ **Antibiotic Ointment:** To prevent infection

___ **Benadryl:** Per label instruction by age/weight, every 6 hours as needed for minor sting/topical reactions to insect bites, poison ivy, oak or sumac

___ **Calamine Lotion:** For dry skin and relieving itch of poison ivy, oak or sumac

___ **Cortisone Ointment:** For exposure to poison ivy, oak or sumac, to relieve itching

___ **Chloraseptic:** One lozenge/spray every 2 hours as needed for sore throat

___ **Eye Drops:** Two drops in each eye twice a day for irritated or watery eyes

___ **Hydrogen Peroxide:** To be used as an antiseptic

___ **Ibuprofen:** Per label instructions by age/weight, every 6 hours as needed for mild headache, musculoskeletal complaints, menstrual cramps

___ **Swim-EAR** 4-5 drops in affected ear 2 times a day for fluid in the ear

I give permission for the use of all the above medications in the treatment of my child marked with an "X". This permission will remain in effect until a replacement order is submitted in writing.

_____ _____ _____

→ **** Physician/Nurse Practitioner Signature** **Date** **Physician's Phone Number**

→ _____ _____

Parent/Guardian Signature **Date**