For Camp Use Only

Cabin or Tent

Name

Camp Cedarbrook in the Adirondacks

The information on this form is required for attendance at camp but is not part of the acceptance process. The information is gathered only to assist us in identifying appropriate care. **ANNUAL UPDATE REQUIRED.**

2018 Adult Health History

Must be completed by adults attending.

Please complete the forms as follows. Keep a copy for your records.

1) **Complete all pages. Attach additional pages as needed.**
2) **Adults attending with child must complete a form for child.**
3) **After both forms have been completed and signed by the parent/guardian and health-care provider, mail forms to Megan Maiello before June 1.**

Address before June 1:
37 East Shore Road, Lake Hopatcong, NJ 07849

Address after June 1:
59 Davignon Road; Corinth, NY 12822

PARTICIPANT CONTACT INFORMATION — PLEASE PRINT

Participant is a: ☐ Staff Member ☐ Volunteer

Name of Participant _____ (LAST / FIRST / MIDDLE) Gender: ☐ Male ☐ Female

Address _____ (STREET ADDRESS / CITY / STATE / ZIP)

Birth Date _____ Age at camp _____

Custodial Parent/Guardian or Emergency Contact

Name _____ Relationship to Camper _____ Phone _____

Home Address (If different from above) _____ (STREET ADDRESS / CITY / STATE / ZIP) Cellphone _____

Second Parent or Guardian or Emergency Contact

Name _____ Relationship to Camper _____ Phone _____

Home Address (If different from above) _____ (STREET ADDRESS / CITY / STATE / ZIP) Cellphone _____

INSURANCE INFORMATION

The participant is covered by family medical/hospital insurance: ☐ Yes ☐ No

If so, indicate the carrier or plan name below:

Insurance Company _____

Policy/Group Number _____

Subscriber _____

Attach photocopy of front of health insurance card here.

Attach photocopy of back of health insurance card here.

IMPORTANT — READ CAREFULLY. These signatures must be provided for attendance.

MENINGOCOCCAL MENINGITIS VACCINATION: I have read, or have had explained to me, the information supplied regarding meningococcal meningitis disease and vaccination. I understand that the vaccine's protection lasts for approximately 3–5 years and that revaccination may be considered within 3–5 years.

MUST CHECK ONE BOX FOR ATTENDANCE.

☐ The participant has had the meningococcal meningitis immunization (Menomune™) within the past 10 years.
Date immunization received: _____

☐ I understand the risks of not receiving the vaccine. I have decided that the participant will not obtain immunization against meningococcal meningitis disease.

HEALTH AUTHORIZATIONS: This health history is correct and accurately reflects the health status of the participant to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining health-care provider. I hereby give permission to the physician selected by Camp Cedarbrook in the Adirondacks to order x-rays, routine tests, and treatment related to the health of the participant for both routine health care and in emergency situations. If I cannot be reached in an emergency, I hereby give permission to the physician selected by Camp Cedarbrook in the Adirondacks to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for the participant. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form.

IN ADDITION, Camp Cedarbrook in the Adirondacks has permission to obtain a copy of the participant's health record from providers who treat the participant and these providers may talk with the camp's staff about the particpant's health status. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to Camp Cedarbrook in the Adirondacks to arrange necessary related transportation for the participant.

SIGNATURE OF ADULT STAFFER DATE

PARTICIPANT AGREEMENT: I understand and agree to abide by any restrictions placed on my participation in camp activities.

SIGNATURE OF ADULT STAFFER DATE

If for religious or other reasons you cannot sign this authorization, contact the registrar for a legal waiver which must be signed for attendance.

Camp Cedarbrook™ in the **Adirondacks**

2018 Adult Health History

Must be completed by adults attending.

Name _____ Birth Date _____

ALLERGIES

☐ This participant has no known allergies.

☐ This participant is allergic to:
☐ Food ☐ Medicine ☐ Environment (insect stings, hay fever, etc.)
☐ Other

Please describe below all known allergies, reactions seen, and management of the reaction.

RESTRICTIONS

☐ I have reviewed the program and activities of the camp and feel the person can participate without restrictions.

☐ I have reviewed the program and activities of the camp and feel the person can participate with the following restrictions or adaptations. **Please describe below.**

DIET, NUTRITION

☐ This participant eats a regular diet.

☐ This participant eats a regular vegetarian diet.

☐ This participant has special food needs. **Please describe below.**

IMMUNIZATION HISTORY

Provide the month and year for each immunization. Immunizations must be current. Copies of immunization forms from health-care providers are acceptable; please attach to this form.

Immunization	Dose 1 Mo/Yr	Dose 2 Mo/Yr	Dose 3 Mo/Yr	Dose 4 Mo/Yr	Dose 5 Mo/Yr	Most Recent Mo/Yr
Diptheria, tetanus, pertussis (DTaP), (TdaP), (dT), or (TdaP)						
Mumps, measles, rubella (MMR)						
Polio (PV)						
Haemophilus influenza B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox) ☐ Had chicken pox Date:						
Meningococcal meningitis (MCV4)						
Tuberculosis (TB) Test	Date:		☐ Negative		☐ Positive	

If the participant has not been fully immunized, sign the following:
I understand and accept the risks to the participant from not being fully immunized.

SIGNATURE OF ADULT STAFFER DATE

Camp Cedarbrook™ in the **Adirondacks**

2018 Adult Health History

Must be completed by adults attending.

Name _____ Birth Date _____

CIRCLE Y FOR YES, N FOR NO.

GENERAL MEDICAL HISTORY

1. **Y N** Do you currently have an ongoing medical condition?
   If yes, please identify:
   - ☐ Asthma
   - ☐ Anemia
   - ☐ Diabetes
   - ☐ Infections
   - ☐ Sickle cell disease or other blood disorders
   - ☐ Other:
2. **Y N** Have you ever had surgery?
3. **Y N** Has a doctor ever told you that you have (check all that apply):
   - ☐ High blood pressure
   - ☐ Kawasaki disease
   - ☐ A heart murmur
   - ☐ A heart infection
   - ☐ Other:
4. **Y N** Have you ever had an unexplained seizure?
5. **Y N** Do you regularly use a brace or assistive device?
6. **Y N** Do you currently have a bone, muscle, or joint injury that bothers you?
7. **Y N** Do you have a history of juvenile arthritis or connective tissue disease?
8. **Y N** Were you born without or are you missing a kidney, an eye, spleen, or any other organ?
9. **Y N** Do you have any rashes, sores, or other skin problems?
10. **Y N** Have you ever had a herpes or MRSA skin infection?
11. **Y N** Have you ever had a head injury or concussion?
    If yes, date of last injury:
14. **Y N** Had problems with diarrhea/constipation?

Please explain Y answers, noting the question's number. The camp may contact you for additional information. *Attach additional pages as needed.*

CIRCLE Y FOR YES, N FOR NO.

ADDITIONAL INFORMATION

17. **Y N** Had problems with falling asleep/sleepwalking?
18. **Y N** Have a history of bed-wetting?
19. **Y N** Do you have any learning disabilities or problems reading aloud in front of a group?
20. **Y N** Have you ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (ADHD)?
21. **Y N** Have you ever been treated for emotional or behavioral difficulties or an eating disorder?
22. **Y N** Do you now, or have you ever, suffered from anxiety?
23. **Y N** During the past 12 months, have you seen a professional to address mental/emotional health concerns?
24. **Y N** Have you ever had a significant life event that continues to affect your life? (Abuse, death of loved one, family change, adoption, foster care, new sibling, survived a disaster, etc.)

Please explain Y answers, noting the question's number. The camp may contact you for additional information. *Attach additional pages as needed.*

Please provide any additional information about the participant's health that you think important or that may affect the camper's ability to participate fully in the camp program. *Attach additional pages as needed.*

Camp Cedarbrook™ in the **Adirondacks**

2018 Adult Health Recommendations

Must be completed/signed by adults attending.

Name _____ Birth Date _____

STANDARD OVER-THE-COUNTER/PRN MEDICATIONS—INDIVIDUALIZED ORDERS The following non-prescription medications may be stocked in the camp health center and are used on an "as needed" basis to manage illness and injury if approval is indicated below by the participant's healthcare provider.

DRUG **Dosage:** Per label instructions by age/weight	**SCHEDULE AND INDICATIONS**	**CAMP HEALTHCARE PROVIDER ORDER** All drugs may be given unless noted below.
Acetaminophen (Tylenol)	Every 4 hours PRN pain or fever > 101F	
Aluminum/Magnesium antacid (Maalox)	Every 4 hours PRN heartburn or stomach upset	
Bacitracin or triple antibiotic (Neosporin)	PRN minor cuts or burns	
Benzocaine/menthol (Cepacol/Chloraseptic) lozenge	PRN sore throat or cough	
Bismuth subsalicylate (Pepto-bismol)	PRN stomach upset or diarrhea	
Calamine lotion	PRN itching, insect bites	
Calcium carbonate (Tums)	Every 2 hours PRN heartburn or stomach upset	
Cetirizine (Zyrtec)	Every 24 hours PRN itching/watering eyes, runny nose, sneezing, or itching	
Chlorpheniramine maleate or Brompheniramine maleate (Dimetapp)	PRN rhinitis or urticaria	
Clotrimazole (Lotrimin), Miconazole (Desenex), Terbinafine (Lamisil), or Tolnaftate (Tinactin)	PRN tinea pedis	
Dextromethorphan (Robitussin DM)	Every 4 hours PRN cough	
Diphenhydramine (Benadryl)	Every 6 hours PRN itching or allergic reaction	
Guaifenesin or Doxylamine (Robitussin)	Every 4 hours PRN cough	
Hydrocortisone acetate (Cortaid) 1%	PRN itching or mild sunburn	
Ibuprofen (Advil, Motrin)	Every 6 hours PRN pain or fever > 101F	
Isopropyl alcohol 95% / anhydrous glycerin 5% (Swimmer's Ear Drops)	PRN retained water in ear canal	
Lidocaine 0.5% (Solarcaine)	PRN mild sunburn or itching due to bug bites	
Loperamide (Imodium/Kaopectate)	PRN diarrhea	
Mentholated cough drops (generic)	PRN sore throat or cough	
Milk of Magnesia	PRN heartburn, stomach upset, or constipation	
Phenylephrine (Sudafed PE)	Every 4 hours PRN upper respiratory tract congestion	
Pseudophedrine (Sudafed)	Every 6 hours PRN upper respiratory tract congestion	
Pyrethrins (Rid) or Permethrin (Nix)	PRN pediculosis	
Simethicone (Gas-X)	Every 4 hours PRN heartburn, stomach upset	

MEDICATIONS Please list the patient's current regimen of medications—both scheduled and as needed. As defined by the NYSDOH a "medication" is ANY substance taken to maintain or improve health. This includes over-the-counter medications, prescription medications, vitamins, and natural remedies. **NYSDOH requires a physician's signature AND Parent/Guardian signature on an "APPROVED FORM" to authorize any medication (as defined above) dispensed by our camp nurse to your child. Keep ALL medications in the original packaging. Prescription medications must show name of participant, physician, name of medication, dosage, and frequency of use.** Provide enough medication to last the entire camp stay. Any medications (as defined above) which are brought to camp that are not included below will NOT be administered.

☐ This participant will not take any daily medications while attending camp. ☐ This participant will take the following daily medication(s) while attending camp.

DRUG	**DOSAGE**	**SCHEDULE AND INDICATIONS**

You will NOT receive any medications unless this form is completed and signed.

Adult Participant:

STANDARD OVER-THE-COUNTER/PRN MEDICATIONS I hereby give permission for Camp Cedarbrook in the Adirondacks to administer the over-the-counter medications (namebrand or generic) as shown above, if the camp nurse deems it necessary. Dosages will be administered as physician directs.

SIGNATURE OF ADULT STAFFER DATE