

Sprucelands Equestrian Camp

- 2 wks June 26-July 9
- 2 wks July 10-23
- 2 wks July 24-August 6
- 2 wks August 7-20

2011 Health History and Examination Form **Session:**

The information on this form is gathered to assist us in providing appropriate care. Health history must be filled out by **parents/guardians of minors or by adults themselves**. Physician's section must be signed by approved **licensed medical personnel**.

All medical forms must be filled out ANNUALLY.

Name: _____ Birth Date: _____ Age at camp _____

Home Address: _____

Custodial parent/guardian: _____ Home phone: _____

Address: _____ Cell phone: _____
(If different from above)

Second parent/guardian: _____ Home phone: _____

Address: _____ Cell phone: _____

If not available in an emergency, notify:

Name: _____ Home phone: _____

Relationship: _____ Cell phone: _____

****Important - this information must be completed for attendance****

Is the participant covered by medical insurance? Yes/No

*****Photocopy front and back of insurance card & attach to form*****

Parent/guardian authorizations:

The person herein described has permission to engage in all camp activities except as noted.

I hereby give my permission to the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child.

In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by Sprucelands to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

This health history is correct and complete to the best of my knowledge.

Signature of parent/guardian or adult camper/staff _____

Printed name _____ Date _____

Health History

Please attach copy of immunizations records

Allergies:

No known allergies:

Life Threatening: _____

Medications: _____

Please describe reaction: _____

Food: _____

Other: _____

Food Restrictions: _____

Activity Restrictions: _____

Medical History:

Surgical History:

Has your child been evaluated or treated for any mental health or behavioral issues in the past 5 years? (such as ADHD, eating disorders, anxiety, etc...)

Name of family physician _____ Phone _____

Address _____

Name of family dentist/orthodontist _____ Phone _____

Address _____

Over the Counter/Prescription Medication Form

MUST BE COMPLETED BY PHYSICIAN

Individual orders for: Name: _____ DOB: _____

Height: _____ Weight: _____ Medication allergies: _____

If you wish your child to receive **ANY** medication, the **New York State regulation requires written permission from your health care provider and parent.** This includes all prescriptions and/or over the counter medications. This written permission must be **renewed annually.** Prescription bottles must have actual prescription labels on them for safety reasons. Administration of over the counter medications will be “per label” directions for age/weight unless otherwise indicated by provider.

| Drug Name | Provider Order | Drug Name | Provider Order |
|---|----------------|---|----------------|
| Acetaminophen (fever/discomfort) | Yes/No | Caladryl (skin irritation/itching) | Yes/No |
| Ibuprofen (fever/discomfort) | Yes/No | Triple antibiotic ointment (Neosporin) minor cuts | Yes/No |
| Benadryl (allergies) | Yes/No | Hydrocortisone cream 1% (skin irritation) | Yes/No |
| Claritin (allergies) | Yes/No | Aloe gel (Sunburn) | Yes/No |
| TUMS (heartburn/upset stomach) | Yes/No | RID or equivalent (lice) | Yes/No |
| Saline eye drops (eye irritation) | Yes/No | Eye wash | Yes/No |
| Phenylephrine (Sudafed) (Nasal discomfort/congestion) | Yes/No | | |

Current Prescriptions and Over-The-Counter Medications:

I assess this person to be self-directed and may self-carry & apply the following:

Bug spray

Sunscreen

I assess this person to be self-directed and may self-carry the following medication:

Inhalers (asthma)

Epi-pen

I assess this person to be free from contagions & physically qualified to participate in all camp activities

Provider Signature _____ **Date:** _____

Printed Name _____

Parent/Guardian Signature _____