Camp Hickory Hill
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Senior Staff Health Form

This form is to be accurately completed and submitted 2 weeks prior to arriving at camp.

Parents, please bring a copy of this form with you to camp.

Staff Member Name: _____

Dear Staff Member,

This form is required for all staff members. During your time at camp, there will be a Camp Health Director at camp to provide for any health care needs of all campers and staff. In addition to the use of basic medical supplies to provide for general health care, the Camp Health Director is able to consult with an area M.D., P.A. or C.N.P. should the need arise. There is a local hospital approximately 15 miles away where emergency services are available at all times. Please review the following general prn orders and if necessary consult your doctor. To make changes, cross out standing orders if necessary and write new orders into the third column under "Doctor's Orders", including any additional OTC or prescription medications. Your signature at the bottom will authorize the Camp Health Director to administer treatment should you require general health care during your time at camp. (The Camp Health Director meets all certification standards according to the New York State Sanitary Code for Overnight Camps – He or she is typically an RN, but may be an EMT, LPN, MD, PA or CNP.)

Please attach a copy of the your immunization records. If you do not have immunization please indicate such in the "additional information" section.

Orders for Camp Nursing Care

Patient presents with:	Standing Orders	Doctor's Orders in place of Standing Orders
Seasonal Allergy Symptoms	Benadryl, Loratadine, Cetirizine, or Fexofenadine per dosing instruction.	
Mild Pain	Tylenol or Ibuprofen per dosing instruction.	
Any Anaphylactic Reaction (bee sting, allergy, etc)	Give epinephrine (bee sting kit) and call 911 immediately.	
Stomach upset	Assess for dehydration, give clear liquids. Tums may be given for acid indigestion.	
Fungal-type Skin infections	Apply Clotrimazole cream per dosing instruction.	
Persistent Cough	Mucinex per dosing instruction	

List all Allergies:

Food: _____

Medications: _____

Other: _____

List any food or activity restrictions:

_____

_____

_____

STAFF MEMBER'S NAME: _____

Please list ALL medications (including over the counter or nonprescription drugs) taken routinely.

Medication	Dosage	Specific times taken each day	Purpose

Attach additional pages for more medications.

ADDITIONAL PRN MEDICATIONS THAT MAY BE GIVEN: _____

_____

MEDICATION RESTRICTIONS: : _____

_____

☐ Please check if you must keep your inhaler with you at all times.

Date of last physical exam: _____

Additional information for the health care staff at Camp Hickory Hill pertinent to this patient:

_____

_____

Emergency Contact Information

Name: _____ Phone #: _____

The following information is regarding your health insurance

Insurance Company: _____Policy # _____

Policy Holder's Name: _____ Insurance Co Phone # _____

I am able to participate in an active camp program. I authorize the camp health officer to administer treatment as necessary according to the standing orders.

X

_____

***Signature of Staff Member** **Date**