Camp Hickory Hill
2970 Kohler Rd.
Varysburg, NY 14167
Ph: (585) 535-7832

Junior Leader Health Form Instructions

Instructions for Completing the Health Form

1. Page 1 is to be completed and signed by the participant's parent or guardian.
2. Pages 2-3 are to be completed by the participant's health care provider. Please provide pages 2-3 to the participant's doctor well in advance and have them return it to directly to you.
3. Review the form to ensure all 3 pages, along with any attached immunization records, are complete and accurate and keep them together for when you come to camp.
4. Bring the completed form with you to camp when you first arrive.

Please note that this form has specific information required for NYS overnight camps, including standing orders. School health forms and physical forms are not adequate substitutes. Please ensure this form is completed.

If you have issues getting the form completed by a doctor, or have questions about the requirements of the form, please contact us in advance so that we can assist you in ensuring that you can be well cared for while at camp.

info@camphickoryhill.org
or
(585) 535-7832

Sincerely,
The Camp Hickory Hill Team

Camp Hickory Hill
2970 Kohler Rd.
Varysburg, NY 14167
Ph: (585) 535-7832

To be completed by
Parent / Guardian

This form MUST be accurately completed for each participant and submitted prior to check-in at camp. This form is to be completed by the participant's parent or guardian. In addition to this form there is a separate form to be completed by the participant's Health Care Provider.

Camp Hickory Hill is located on a hillside and will be physically challenging if your child's mobility is limited or health is otherwise impaired. Please be certain your child is in good health and up to the physical demands upon arrival at camp. We will be unable to safely accommodate some types of medical conditions. Please contact the camp if you have questions regarding this health form.

Please be advised that we are subject to New York State laws and require the EXACT information requested.

Participant Name _____ **Gender M F Date of Birth** _____

Address _____ **City** _____ **State**_____ **Zip**_____

PRIMARY PERSON TO CONTACT IN CASE OF EMERGENCY: (Parent/Guardian)

Name _____ Relationship to participant_____ Phone _____

Health Insurance Information

Carrier _____ Type _____

Policy # _____ Phone # (___) _____

In Whose Name? _____

IMMUNIZATIONS - Please make sure a record of immunizations is provided by the participant's medical care provider. If no immunizations have been given, we must have documentation of that.

☐ My child may carry and use the insect repellent that is sent with him/her to camp. If my child is unable to physically apply insect repellent, he/she may be assisted by an approved camp staff member if my child requests it. (Check box to left to authorize)

Parent's Authorization (must be signed): The information in this form is correct, and the person herein described has permission to engage in all camp activities, except as noted on this form. In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for my child as named above. I also authorize the camp nurse to administer treatment as per standing order protocol and to administer any medications prescribed by his/her physician as listed on the Health Care Provider Form.

Parent/Guardian Signature	Relationship	Date

*IMPORTANT! PLEASE READ:

Please be sure to submit the Health Care Provider Form to your child's pediatrician for their review and signature. Typical school health assessment or sports forms are not acceptable, as they do not authorize general medical care for your child in the event it is required. If your child takes medication, bring enough medication to last the entire time at camp. **Keep all medication in the original and current packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.**

Camp Hickory Hill

To be completed by Health Care Provider

Dear Health Care Provider,

Your patient:_____DOB:_____is applying to attend summer camp. There will be a Camp Health Director at camp during the week to provide for any health care needs. Your office and the participant's parents would also be contacted should the situation warrant. There is a local hospital approximately 15 miles away where emergency services are always available. Please review the following general prn orders and make changes by crossing out standing orders if necessary and writing 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 personnel to administer treatment should your patient require it during their stay at camp. The Camp Health Personnel meet all certification standards according to the New York State Sanitary Code for Overnight Camps.

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 Epi-pen and call 911 immediately.	
Contact Dermatitis/Skin Allergies	Apply hydrocortisone cream per dosing instruction.	
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: _____

Insect Stings: _____

Other: _____

List any food or activity restrictions:

_____

_____

_____

Record of Immunizations: (or attach a copy of immunization records) ☐ Check here if no immunizations

Type: _____ Date: _____ Type: _____ Date: _____

Type: _____ Date: _____ Type: _____ Date: _____

Type: _____ Date: _____ Type: _____ Date: _____

Type: _____ Date: _____ Type: _____ Date: _____

PARTICIPANT'S NAME: _____

Please list **ALL** medications **(including over the counter, nonprescription, vitamins, or supplements)** taken routinely. No OTC medications including vitamins and supplements may be given unless listed below or as a standing order on the previous page of this form.

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 the patient must always keep their inhaler with them.

☐ Date of last physical exam: _____ (does not need a physical to attend camp)

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

_____

_____

In my opinion, the above registrant is able to participate in an active camp program.

Signed: _____

***Signature of Licensed Medical Personnel (MD, PA, or CNP ONLY)**

**This signature is required for any camper or for any staff member under the age of 19. By signing this form, the MD, PA or CNP is indicating they have read both pages of this health form. An electronic signature is acceptable.*

Printed Name of Physician: _____ Date: _____

Physician's Professional License Number: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____