Camper's Name: _____ Date of Birth: _____ Session _____ Year _____

# Camp Turner Health Forms v. 2023
# PLEASE READ THESE INSTRUCTIONS

## Instructions for Physician's office

- Complete page 3 & 4, including medication authorization.
  - Campers may not attend without these pages completed.
  - Campers need your authorizations for all supplements including vitamins, melatonin, etc.
- attach Immunization Records
- attach results of most recent physical
- Return pages to parents so parents can send ***all pages as one packet.***

## Instructions for Parents:

- KEEP ALL 4 PAGES and the Physical and Immunization records together.
- Do not send pages separately.
- Do not double side forms.
- **Copy and retain all original pages.**
- Bring originals to check in as backup.
- Do not upload Forms or Photos into your online account.
- Health Forms are due at camp at least ***one week before arrival***.
- We must have written orders for these as well as prescriptions. Tell your doctor if your camper needs melatonin, vitamins, etc. so the doctor can authorize them.
- Parents complete pages 1 and 2.
- Attach a paper photo of camper's face to the paper page 1.
- Mail copies of all pages (pages 1-4, plus immunization records and physical) to Camp Turner, PO Box 264, Salamanca, NY 14779 at least 10 days before scheduled arrival.
- Campers who sign up for the optional trip (offered some sessions to ages 13 and up, see summer schedule) to the High Ropes Course, will need to download and complete a separate permission form. Check the website for details.

Camper's Name: _____ Date of Birth: _____ Session _____ Year _____

This page intentionally blank.

Camper's Name: _____ Date of Birth: _____ Session _____ Year _____

*Page 1*

# Camp Turner Health Forms v.2023

## Camper Information (by parent)

Attach a clear, color photo of your camper's face here

Camper's Full Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Gender: _____

Height: _____ Weight: _____ Eye Color: _____ Hair Color: _____

_____ _____
Arrival Date Age upon arrival

_____
**Parent / Guardian name** Home Phone Work Phone Cell Phone

_____
Second Parent / Guardian name Home Phone Work Phone Cell Phone

_____
Emergency Contact (third option) name Home Phone Work Phone Cell Phone

_____
Agency Contact if any name Home Phone Work Phone Cell Phone

_____
Primary Health Insurance Carrier Group ID Number Policy Holder's Name ID Number

_____
Camper's Primary Care Physician Physicians Location Phone Fax

**No contact allowed with** _____

**Medication Allergies:** _____

**Food Allergies:** _____

**Activity Restrictions:** _____

**Dietary Restrictions:** _____

**Eating Disorder**: _____

**Threatened or attempted suicide**? _____

**Other trauma we need to be aware of:** _____

**Notes for the nurse:** _____

_____

**Attach additional pages if needed.**

**Parents, please write a separate note to the cabin counselor to be delivered by you and discussed upon arrival.**

Camper's Name: _____ Date of Birth: _____ Session _____ Year _____

# *Page 2*

**PARENTS: Please report answers to the following for your camper.**

Recent illness or injury: _____

Recent hospitalization: _____

Infectious / communicable disease: _____

Have wheezing or shortness of breath? _____

Seizures: _____

Loss of Consciousness: _____

Diabetes: _____

Other chronic condition: _____

Had fainting or dizziness: _____

Passed out or had chest pain during exercise: _____

Had problems falling asleep or sleep walking: _____

Back or joint pain: _____

Skin Problems: _____

Abnormal Menstruation: _____

Have a history of bed wetting or incontinence: _____

Problems with diarrhea or constipation: _____

Traveled outside the US in the last 9 months: _____

Swimming Ability: _____

Behavior Issues: _____

Emotional Issues: _____

ADD / ADHD: _____

Chronic Fears: _____

Family Issues: _____

Personal crisis**:** _____

**Permission to treat**: By my signature below I give my permission to the representatives of Camp Turner to seek out and authorize emergency medical treatment including ordering x-rays or other routine tests, or surgical treatment that may be considered necessary or advisable in the event that I cannot be reached in a reasonable amount of time. I authorize any licensed physician or medical center chosen by representatives of Camp Turner to treat my child. I agree to the release of any records necessary for insurance purposes. I agree that my health insurance will be the primary payer for all medical care, treatments, legal services or other necessary services received by or performed on my child while in the care of Camp Turner or its agents.

I agree to allow my camper's pediatrician to release medical records including immunization records and results of most recent physical to Camp Turner via the camp's Registered Nurse.

By the signature below, I attest that all the information is **complete** and **accurate** to the best of my knowledge and belief. I understand that this information is confidential and will only be shared with those in direct care of my child.

_____ _____ _____

Signature of Parent or Legal Guardian Printed Name Date Signed

Camper's Name: _____ Date of Birth: _____ Session _____ Year _____

# *Page 3*

## *Physician's Office, please:*

- ***Attach current Immunization Records.***
- ***Attach most recent physical.***
- ***Complete medication authorization below / or provide written orders.***
- ***Sign / stamp the bottom of this page.***

**We have written orders from the physician to administer prescription OR over-the-counter medications. The orders may be written below, or provided on the physician's letterhead or script. Medication will only be accepted in original containers. All medications are locked in the infirmary and administered under the supervision of our nurses.**

## Circle "YES" to authorize OR circle "NO" to disallow

| Drug | Use | Approval | Comments, recommendations, restrictions |
|---|---|---|---|
| Tylenol or children's Tylenol. | Pain / fever / headache | **Yes / No** | |
| Ibuprofen or children's Ibuprofen | Pain / fever / headache | **Yes / No** | |
| Tums | Upset stomach | **Yes / No** | |
| Benadryl or equivalent | Allergic reaction, insect bites, ALLERGY reactions. | **Yes / No** | |
| Cetirizine HCL (Zyrtec) | Allergy Relief | **Yes / No** | |
| Loratadine (Claritin) | Allergy Relief | **Yes / No** | |
| Cough Drops | Sore or scratchy throat | **Yes / No** | |
| Sore Throat Spray | Sore or scratchy throat | **Yes / No** | |
| Band Aid Cleansing Foam (or similar) | Cleaning cuts or scrapes | **Yes / No** | |
| Triple Antibiotic Cream | Apply to cuts or scrapes | **Yes / No** | |
| Burn gel (after ice) | Sunburn other minor burns | **Yes / No** | . |
| Desitin (zinc oxide cream) | Rash (self-administered by camper) | **Yes / No** | |
| Caladryl lotion | Insect bites, plant reactions | **Yes / No** | |
| Tussin DM | Cough | **Yes / No** | |
| Benzocaine (Sting Ease / After Bite) | For insect bites after icing. | **Yes / No** | |
| Miralax / Clearlax | For Constipation | **Yes / No** | |
| Sunscreen | Prevent sunburn – self-administered by camper with staff assistance as needed. | **Yes / No** | |
| Insect Spray | Prevent insect bites – self-administered by camper with staff supervision and assistance as needed. | **Yes / No** | |
| Melatonin 1 mg | Now stocked due to popular demand. | **Yes / No** | Please indicate authorized dosage: _____ |

Other medications authorized not listed above including including **vitamins, melatonin, etc.**

| Medication | Route | Dose | Schedule | Diagnosis – Reason for taking |
|---|---|---|---|---|
| | | | | |
| | | | | |

Camper's Name: _____ Date of Birth: _____ Session _____ Year _____

This patient's last physical exam was on _____
Date

At the time of this examination this patient is:

_____ Recommended for a highly active overnight camping program. Participation poses no Foreseeable health risk to this patient OR to others living, eating and sleeping in proximity

_____ Recommended with these **restrictions:**

_____

_____

_____

COMPLETE MEDICATION AUTHORIZATION ABOVE!

Attach Physical and Immunization Records!

_____
Printed Name of Healthcare provider Signature Date

_____
Location Phone Number

Physicians Stamp: