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

Camp Turner Health Form
PLEASE READ THESE INSTRUCTIONS

Instructions for Parents:

- Complete pages 1 and 2.
- Visit your doctor to have pages 3 and 4 completed.
- Note, many doctors will take 10 days to complete your forms.
- Collect pages 3 and 4, from your doctor.
- Collect immunization records and results of most recent physical from your doctor.
- Make copies of all the documents.
- Fax the originals to Camp Turner at 716-354-4555, or mail them to PO Box 264, Salamanca, NY 14779.
- Keep a copy of the originals to bring with you to check in.
- **DO NOT upload Forms or Photos into your online account.**
- **Do NOT email forms.**
- Health Forms are due at camp at least ***one week before arrival***.

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 and Health History***
- attach results of most recent **physical.**
- **We accept physicals up to 18 months old.**
- Return pages to parents so parents can send ***all pages as one packet.***

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

This page intentionally blank.

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

PARENT 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 _____________

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

PARENT 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 _____

PHYSICAN'S Page 1

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 _____

Physician's Page 2

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: