NYSDEC ENVIRONMENTAL EDUCATION SUMMER CAMPS Bunk #_____

HEALTHCARE PROVIDER FORM **– MUST BE COMPLETED BY A LICENSED HEALTHCARE PROVIDER**

MUST BE SIGNED BY LICENSED HEALTHCARE PROVIDER AND PARENT/GUARDIAN

This health form is for a one-week session of camp – less than 7 consecutive nights.
No substitutions with another form will be accepted.

Camper's Name: _____ Date of Birth:_____

Healthcare recommendations by licensed healthcare provider ONLY.

I examined this individual on _____ *(must be within the previous school year to be accepted)*

BP _____ Weight _____ Height _____

In my opinion, the above camper/staff: [ ] **is** / [ ] **is not** able to participate in an active camp program.

The camper/staff is under the care of a physician for the following conditions: _____

_____

Any medically prescribed meal plan or dietary restrictions: _____

_____

Known allergies to medications, food, or other (insect stings, asthma, animals, etc.): _____

_____

Description of any limitation or restriction on camp activities (use additional sheets if necessary): _____

_____

Additional information for healthcare staff at the camp to be aware of: _____

_____

PLEASE NOTE THAT CAMP HEALTH DIRECTORS ARE EMTs.

EMTs **cannot** do diagnostic procedures or distribute 'AS NEEDED' OR 'PRN' medication.

'PRN'/'AS NEEDED' cannot be accepted. ALL MEDICATIONS, INCLUDING OVER-THE-COUNTER (OTC)**, MUST BE SCHEDULED.**

1. Please complete with patient's current regimen for scheduled medications.
2. All medications must be in original container.
3. All OTCs must be listed with exact dosage and schedule.
4. Writing **'may refuse'** in the comments indicates that the camper will be offered the medication at the scheduled time but may refuse. Acceptable alternative for PRN/As Needed.
5. Medications will be self-administered and witnessed by Camp staff and stored in a double locked area unless self-carry is indicated.
6. **Self-carry** release for epi-pens, insulin pumps, and Albuterol/Proventil or other rescue inhalers must be indicated on the chart.

Drug Name	Route	Dosage	Schedule and Indications	Comments
SAMPLE NAME	*BY MOUTH*	*# MG*	*AT BED TIME*	*MAY REFUSE*

Date of last TB Mantoux Test:		Result:	Positive	☐	Negative	☐	N/A	☐

Parents/Guardians please review camp-specific vaccination requirements/recommendations within the Camper Handbook.

Please fill out this table in addition to providing all dates of immunization history. Evidence of immunity must be attached separately and may include the following:

a) Written documentation from a health care provider of one or more doses of a measles containing vaccine (MMR);
b) Laboratory evidence of immunity;
c) Laboratory confirmation of measles; or
d) Birth before 1957

	Diphtheria and Tetanus toxoid-containing vaccine and Pertussis vaccine (Dtap/DTP/Tdap)	Hepatitis B vaccine OR proof of immunity	Measles, Mumps and Rubella vaccine (MMR) OR proof of immunity (positive titer)	Polio Vaccine (IPV/OPV)	Varicella (Chickenpox) vaccine OR proof of immunity	Meningococcal conjugate vaccine (MenACWY)
Administered prior to start of camp **OR** evidence of immunity	☐	☐	☐	☐	☐	☐
Not administered / No evidence of immunity	☐	☐	☐	☐	☐	☐

Print out of vaccination record is acceptable for this section ONLY and must be attached with this form.

Has the camper contracted any of the following, listed below? Check if YES		Please give all dates of immunization for:						
		Vaccine	Month/Year	Month/Year	Month/Year	Month/Year	Month/Year	Month/Year
		DPT						
		TD (tetanus/diphtheria)						
		Tetanus						
		Polio						
		MMR						
		or Measles						
☐	Measles	or Mumps						
☐	Chicken Pox	or Rubella						
☐	German Measles	Haemophilus influenzae B						
☐	Mumps	Hepatitis B						
☐	Hepatitis A	Varicella (Chicken Pox)						
☐	Hepatitis B	Meningococcal Meningitis						
☐	Hepatitis C	COVID-19						

Camper's Health Care Provider Information

Name: _____ Address: _____

Phone: _____ Fax: _____

Signature: _____ Date: _____License #: _____

Camper's Parent/Guardian Information

Name: Signature: Date: