Kesher Scouting / Kesher Tech / Camp Kochavim
150 Nashopa Road, Bloomingburg, NY 12721 Tel: 1-855-4-KESHER

CAMPER MEDICAL FORM

NO FAX SUBMISSIONS …… ORIGINAL FORMS ONLY

Completed forms must be returned BY MAIL to: Kesher Camps, 3905 Bancroft Road, Baltimore, MD 21215

Camper's name: ___________________________ Home Phone: ______________________________

Home address: ____________________________ Summer Phone: ____________________________

City/State/Zip ______________________________ Mother's Work: ____________________________

Summer Address: __________________________ Mother's Cell: ______________________________

City/State/Zip: _____________________________ Father's Work: _____________________________

Date of Birth: ________________ Age: ______ Father's Cell: ______________________________

Summer of attendance: ______________ Email address: ____________________________

EMERGENCY CONTACT:

Name: ___________________________ Phone Number _____________________ Relationship to camper: __________________

If your child has a chronic or acute medical condition, it is imperative that the camp be notified. To contact the camp medical staff regarding your child's confidential medical information, please email nurse@campkochavim.com before June 1 and the Health Administrator or nurse will call you to discuss. All information will be held confidential.

MEDICAL & PRESCRIPTION DRUG INSURANCE INFORMATION

Please make a copy of your medical insurance card (front and back) and paste it in the spaces provided below. If you have separate prescription drug coverage, make a copy of that card (front and back) and place them both in the space below on the right.

If no cards are attached, or the information is illegible, you will be billed for your child's medical treatment and prescription drugs at regular rates.

Attach a copy of the front of of your medical insurance card here.	Attach a copy of the back of your medical insurance card here.	Attach a copy of your prescription drug card (front and back) here.

Please complete the insurance information section below (PLEASE PRINT LEGIBLY)

Primary Insurance carrier: ___________________________ Group Name & Number: ____

Identification Number: ___________________________ Co-payment: ___________________

Policyholder Name: _________________________ DOB: ____________________ Relationship to camper: __________________

Other/secondary insurance carrier and identification information, if different from above: ___________________________________

To assist us in the care of your child, please detail any special circumstances or conditions that our medical or counseling staff should be aware of (e.g. frequent colds, headaches, stomachaches, diarrhea/constipation, vomiting, bedwetting, sensitivity to insect bites, homesickness, nightmares, anxiety reactions etc.),and what you would recommend as treatment:

____

IMPORTANT NOTE: THE CAMP OFFICE MUST BE NOTIFIED IF YOUR CHILD IS EXPOSED TO ANY COMMUNICABLE DISEASE DURING THE THREE WEEKS PRIOR TO CAMP ATTENDANCE.

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TO BE COMPLETED BY PARENTS

DEPARTMENT OF HEALTH REGULATIONS REQUIRE THE FOLLOWING AUTHORIZATIONS IF YOUR CHILD ATTENDS A SLEEP-AWAY CAMP

PARENTS' AUTHORIZATION TO TREAT

1. This health history is correct as far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted by me and the examining physician.
2. I hereby give permission to the physician selected by the camp director to order x-rays, routine tests and treatment for the health of my child. In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, order injections and/or anesthesia and/or surgery for my child as named above.

MENINGITIS VACCINATION RESPONSE

3. NYS Public Health Law requires the operator of an overnight children's camp to maintain a completed response form for every camper who attends camp for seven (7) or more nights

I have read the camp letter describing Meningitis, its transmission, the benefits, risks and effectiveness of immunization, (Please check one box and sign below:)

☐ My child has had the meningococcal meningitis immunization (Menomune) within the past 10 years. Date received: __________________ (Note: The vaccine's protection lasts approximately 3-5 years. Re-vaccination may be considered within 3-5 years.)

☐ I have read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that my child will not obtain immunization against meningococcal meningitis disease.

Parent(s) signature: ______________________ Date: _______________ Phone #: ___________________

Witness signature: _______________________ Date: _______________

AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR TEMPORARILY SEPARATED FROM HIS/HER PARENTS

I/We, the undersigned parents of, ________________________ a minor, do hereby authorize Camp Kochavim and Kesher Scouting / Kesher Tech as our agent(s) to consent to any diagnostic procedure or medical care for said child which is deemed advisable by, and is rendered under the general or special supervision of any licensed physician or surgeon at Catskill Regional Medical (formally Community General Hospital of Sullivan County) or at any other accredited hospital, when such diagnosis or treatment is rendered at said hospital.
It is understood that this authorization is given in advance of any specific need for treatment, but is given to provide authority on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the physician in the exercise of his best judgment may deem advisable.
This authorization shall remain effective until August 24, 2011, unless sooner revoked in writing and delivered to said agent(s).

Parent(s) signature: ________________________ Date: ________________ Phone #: ____________________

Witness signature: __________________________ Date: ________________

TO BE COMPLETED BY EXAMINING PHYSICIAN

Camper's name: ______________________________

Home address: ______________________________

Home Phone: ______________________________

Physician's name: ______________________________

Home address: ______________________________

Home Phone: ______________________________

Immunization History:

Please record month and year of basic immunizations and most recent booster.

Immunization	Date basic series completed	Most recent booster
DPT or DT		
Tetanus		
Oral Polio		
MMR		
HIB		
Hepatitis A		
Hepatitis B		
Varicella		
Haemophilus Influenza B		

Allergies:	YES	NO	Comments
Penicillin			
Sulfa			
Cephalosposrins			
Other medication			
Bees/insect bites			
Food allergies			
List foods your child is allergic to.			

Has your child ever had an anaphylactic reaction? Yes No

IF YES, YOU MUST SEND AN EPI-PEN TO CAMP WITH YOUR CHILD. (CHECK THAT IT HAS NOT EXPIRED OR YOU WILL BILLED FOR ONE ONCE YOUR CHILD COMES TO CAMP.)

Medical History: Indicate date of illness		
Chicken Pox	Hepatitis	
Measles	Pneumonia	
German measles		
Mumps		
Indicate if being treated for the following:		
Seizures	YES	NO
Diabetes	YES	NO
Hay Fever	YES	NO
Frequent Ear infections	YES	NO
Frequent Strep throat	YES	NO
Seasonal Allergies	YES	NO
Rheumatic fever	YES	NO
Asthma	YES	NO
PLEASE MAKE SURE THE NURSE IS NOTIFIED BEFORE CAMP BEGINS		
Positive PPD Date:	CXRay: Date:	
Treatment protocol		

Individualized Orders

Standard over-the counter/PRN Medications

(Available in infirmary/First Aid Kit) To be administered at the discretion of the RN unless noted below.

Drug or generic equivalent	Route	Dosage	Schedule	Contraindicated (Check only if not to be given)	Comments
Tylenol	PO	Per label instructions by age/weight	Q 3-4 hr prn For discomfort or elevated temp		
Ibuprofen	PO	Per label instructions by age/weight	Q 6hr prn for Discomfort or elevated temp		
Robitussin	PO	Per label instructions by age/weight	Q 4-6 prn for Cough		
Pepto Bismol	PO	Per label instructions by age/weight	Q 30 min to 1hr prn for diarrhea (not>8 doses/24 hr)		
Mylanta	PO	Per label instructions by age/weight	TID-QID prn for gastric upset		
Dramamine	PO	Per label instructions by age/weight	½ hr b4 embarkation , then q 6-8hr prn for motion sickness		
Dimetapp	PO	Per label instructions by age/weight	Q 6-8 hr for nasal congestion/drainage		
Benadryl	PO	Per label instructions by age/weight	Q 6hr prn for allergic reaction		
Sudafed	PO	Per label instructions by age/weight	Q 6-8 hr for nasal congestion/drainage		
Tums	PO	Per label instructions by age/weight	Q 30 min prn for gastric upset/heartburn		
NaphconA	Eye gtts	Per label instructions by age/weight	1-2 gtts affected eye q 4-6 hr itching/burning		
Milk of Magnesia	PO	Per label instructions by age/weight	BID-TID prn for gastric upset/constipation		
Ear Drops	TOP	Per label instructions by age/weight	Apply to affected area as indicated		
Cortisone Ointment	TOP	Per label instructions by age/weight	Apply to affected area as indicated		
Antifungal Ointment Spray		Per label instructions by age/weight	Apply to affected area as indicated		

List dates & description of operations, serious injuries or fractures: ______________________________

Chronic or recurrent illness and suggested treatment: ______________________________

SPECIAL RESTRICTIONS:

Diet: ______________________________

Strenuous activity: ______________________________

Swimming: ______________________________

Other: ______________________________

To the best of my knowledge the information stated above is true and accurate and it is my opinion that the camper named above in physically able to engage in all camp activities, except as noted above.

Physician's signature: ______________________________ Date: ____________________

Physician's name: ______________________________ Emergency phone #: ____________________

Address: ______________________________