

THIS MEDICAL SECTION IS DUE TO:

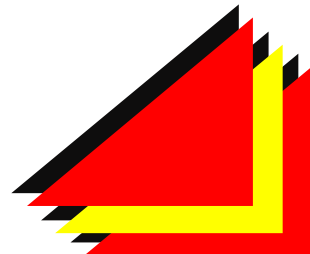
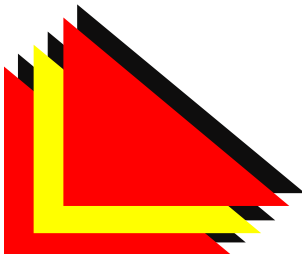
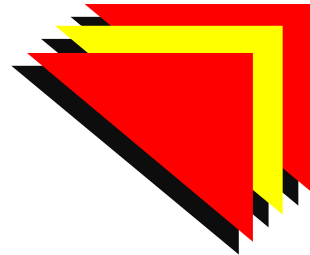
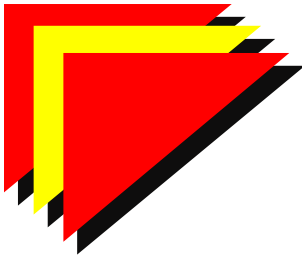
**DPF 4-H Camp Office
Cornell Cooperative Extension
40 Main Street, Lower Level
Hempstead, NY 11550**

by MAY 15, 2009



PLEASE ATTACH A RECENT PHOTO OF THE CAMPER *(ANY SIZE)*

NAME OF CAMPER



REMINDERS: PARENT/GUARDIAN must fill out and sign pages M3 and M4.
PHYSICIAN must fill out and sign Insert page.



▼ IMPORTANT NOTICE ▼

The Department of Health requires that your child's physician complete the **INDIVIDUAL STANDING ORDERS** for camp (ex. below-- copy enclosed) in order for your child to receive any of the over-the-counter medication that we have available in the Health Lodge.

HERE ARE A FEW EXAMPLES:

▼ If your child gets a bug bite and it itches, the nurse can administer Caladryl only if **YES** is circled on the form and the physician has signed it.

▼ If your child has nasal congestion, the nurse can administer Dimetapp only if **YES** is circled on the form and the physician has signed it.

▼ If your child gets a cut, the nurse can administer an antiseptic only if **YES** is circled on the form and the physician has signed it.

INDIVIDUAL STANDING ORDERS FOR CAMPER
D.P.F. NASSAU COUNTY 4-H CAMP 2004

Our nurses can not administer any over the counter or prescription medications unless your health provider has filled out this form.

The NYS Dept. of Health is requiring that summer camps have an individualized set of standing orders for each attending camper. These standing orders specify which over-the-counter medicines carried in the Camp Health Lodge may be administered to an individual camper and under what conditions. The prescription medication section covers prescription medications and other over-the-counter medications that the camper will bring to camp. Please consult with your family healthcare provider and have him/her complete both sides of this form and sign on reverse side.

Camper's name (last, first) _____
 Date of birth _____

Standing Over the Counter Medications - The following medications are available in the Health Lodge and will be administered at the discretion of the Health Director, with physician's approval. Please select which medications below can be administered.

Key: PRN (if needed) PO (taken by mouth) Topical (applied to skin) Q (every)

DRUG NAME	ROUTE	DOSAGE	SCHEDULE AND INDICATIONS	CAMPER HEALTH CARE PROVIDER ORDER	COMMENTS
Acetic Acid Solution	Otic (liquid)	Per label instructions	PRN - Swimmers ear	Yes No	
Anti acid (Mylican or Tums)	PO (pills or liquid)	Per label instruction by age/weight	Q 2-4 hrs PRN-Gas, heartburn, indigestion, stomach upset	Yes No	

YOUR CHILD'S PHYSICIAN MUST SIGN THE INDIVIDUAL STANDING ORDERS TO ENSURE THAT THE CAMP NURSE CAN ADMINISTER OVER-THE-COUNTER MEDICATIONS AVAILABLE IN THE HEALTH LODGE IF YOUR CHILD NEEDS THEM.



Cornell University
 Cooperative Extension
 Nassau County

Nassau County
 40 Main Street, Lower Level
 Hempstead, NY 11550

516 292-7990
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Building Strong and Vibrant New York Communities

Cornell Cooperative Extension in Nassau County provides equal program and employment opportunities.



**MUST BE COMPLETED
BY PARENT/GUARDIAN**

HEALTH HISTORY

CAMPER: _____

NEW YORK STATE requires camps to have a completed health form on each child. This form MUST be submitted no less than 3 weeks prior to the start of your child's camp experience.

MAIL TO:
DPF Nassau County 4-H Camp Office
Cornell Cooperative Extension of Nassau County
40 Main Street, Lower Level
Hempstead, NY 11550

LAST NAME

CAMPER'S NAME _____
Last First Middle Birth date Age Sex

Parent or Guardian _____

Home address _____
Number and Street City/State Zip+4

Phone () _____ () _____ () _____
Day Evening Cell

Other Parent or Guardian _____

Phone () _____ () _____ () _____
Day Evening Cell

IN THE EVENT OF EMERGENCY, AND PARENT OR GUADIAN CANNOT BE REACHED, NOTIFY _____
(Must be over 18 years of age.)

Relationship to camper _____

Phone () _____ () _____ () _____
Day Evening Cell

MEDICAL INSURANCE Camp physician requires a copy of your medical insurance card (front and back). Please attach to this form.

Policy Holder's Name	Name of insurance carrier and type of coverage	Policy No.	Group No.
Authorization for release of information to above named insurance carrier Signature _____ Date _____ Relationship to camper (parent, etc.) _____			
Address of Insurance Company _____ <small>Your personal medical policy is your child's primary coverage. All campers must have medical insurance to attend camp. All registered campers are covered by excess coverage accident insurance while at camp.</small>			

IMPORTANT Please notify the camp office if this camper is exposed to any communicable disease during the three weeks prior to camp attendance.

PERMISSION TO PROVIDE NECESSARY TREATMENT OR EMERGENCY CARE

I certify that the information given in this form and on the attached immunization record is current and correct. I hereby give permission to the medical personnel selected by the Camp Coodinator to order xrays, routine tests, treatment, release any records necessary for insurance purposes, and to provide or arrange for necessary transportation for my child. In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the Camp Coordinator to secure and administer treatment, including hospitalization, for the person named above. This form may be photocopied for trips out of camp.

SIGNATURE OF PARENT OR GUARDIAN: _____



FIRST NAME

1
2
2E
3
3E
4
5
5E
6
6E
7
7E
8

MUST BE COMPLETED BY PARENT/GUARDIAN

HEALTH HISTORY

FILL IN ALL REQUESTED INFORMATION. INCOMPLETE FORMS CANNOT BE PROCESSED AND WILL BE RETURNED.
FORMS ARE DUE BY MAY 15, 2009.

CAMPER'S NAME _____

(Check YES or NO)

- | | | |
|------------------------------|-----------------------------|-----------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | asthma |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | frequent ear infections |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | heart defect/disease |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | convulsions |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | diabetes |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | bleeding/clotting disorders |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | hypertension |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | psychiatric treatment |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | mononucleosis |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | bed wetting |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | fainting |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | eating disorder |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | sleep walking |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | headaches |

Operations or serious injuries (dates): _____

Disability or chronic medical conditions: _____

Current medication (**send in original container with instructions**): _____

Dietary modifications: _____

Any specific activities to be encouraged or limited: _____

Name of dentist/orthodontist: _____

Phone () _____

Name of family physician: _____

Phone () _____

Allergies

- | | | |
|------------------------------|-----------------------------|---------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | hay fever |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | poison ivy |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | insect stings |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | other drugs |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | foods |

Diseases

- | | | |
|------------------------------|-----------------------------|----------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | chicken pox |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | measles |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | German measles |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | mumps |

For females

- Has this person menstruated? Yes No
If not, has she been told about it? Yes No
If she has menstruated, is her menstrual history normal?
 Yes No

Special consideration: _____

MENINGOCOCCAL MENINGITIS VACCINATION

New York State Public Health Law requires the operator of an overnight children's camp to maintain a completed response form for every camper who attends camp.

REQUIRED – PLEASE CHECK ONE BOX AND SIGN BELOW.

- My child has had the meningococcal meningitis immunization (Menomune™) within the past 10 years.

*(Note: The vaccine's protection lasts for approximately 3 to 5 years.
Revaccination may be considered within 3-5 years.)*

Date received _____

Signed (Parent/Guardian) _____ Date _____

- 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.

Signed (Parent/Guardian) _____ Date _____

REQUIRED SIGNATURES

I have read and discussed the 2009 Parent-Camper Handbook with my child. We agree to abide by all policies and procedures contained therein.

SIGNATURE OF PARENT OR GUARDIAN _____

SIGNATURE OF CAMPER _____

PHYSICIAN MUST FILL OUT BOTH SIDES

CAMPER'S NAME _____

MEDICAL EXAMINATION & HEALTH HISTORY

IMMUNIZATION HISTORY

You MUST record the specific date (month and year) of basic immunizations and most recent booster doses:

_____ DPT or DT	_____ Tuberculosis	_____ Haemophilus influenza type B
_____ MMR	_____ Pneumonia vaccination	_____ Varicella (chicken pox)
_____ Other tetanus	_____ Hepatitis B	
_____ Polio vaccine (most recent)	_____ Recent exposure to contagious disease	

This examination should be performed within 12 months of arrival at camp. Examination for some other purpose (ie: sports, school) is acceptable; please provide copy. Examination is for determining fitness to engage in activities. CODE: (blank) = Satisfactory; X = Not satisfactory; 0 = Not examined

Height _____	Heart _____
Weight _____	Abdomen _____
Blood pressure _____	Posture (spine) _____
Eyes _____	Skin _____
Glasses _____	Allergy: <i>please specify:</i> _____
Extremities _____	_____
Ears _____	Lungs _____
Nose _____	Hernia _____
Throat _____	General appraisal _____
Teeth _____	_____

RECOMMENDATIONS/RESTRICTIONS WHILE AT CAMP

Special diet _____
 Swimming _____
 Other _____

FOR GIRLS:

■ Has this person menstruated? _____
 ■ If not, has she been told about menstruation? _____
 ■ If so, is her menstrual history normal? _____

HEALTH HISTORY

List any medical problems, behavior problems, operations, serious injuries or special considerations

Drug allergies _____	Diabetes _____
Asthma _____	ADD/ADHD _____
Seizures _____	Bedwetting _____
Insect stings _____	Sleepwalking _____

Food Allergies—specify	Environmental Allergies—specify	Other Drug Allergies	Other Allergies
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Mental, Emotional and Social Health. Check "Yes" or "No" for each statement.

Has the camper:

- | | | |
|--|------------------------------|-----------------------------|
| 1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (ADHD) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Ever been treated for emotional or behavioral difficulties or an eating disorder? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. During the past 12 months, seen a professional to address mental/emotional health concerns? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Had a significant life event that continues to affect the camper's life? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Please explain "Yes" answers in the space below, noting the number of the question. The camp may contact you for additional information.



PHYSICIAN MUST FILL OUT BOTH SIDES

NOTE: If a licensed health care provider does not sign this form, the camper will not be given any prescription or over the counter medication. Please allow your health care provider ample time to complete this form and return it to us.

HEALTH CARE RECOMMENDATIONS: Please complete with patient's current regimen for both scheduled and prn medications – use 2nd page if needed. Please bring all regularly taken prescriptions to the camp nurse when registering.

A PHYSICIAN, PHYSICIAN'S ASSISTANT OR NURSE PRACTITIONER MUST SIGN THE STANDING ORDERS

Camper's health care provider's name *(please print)* _____

Licensed physician's name *(please print)* _____

Licensed physician's signature _____ License # _____

Address _____ Phone () _____

Date of form completion _____ By _____

Initial if completed by nurse or physician's assistant



78%

DRUG NAME	ROUTE <i>circle preferred formulation</i>	DOSAGE	SCHEDULE AND INDICATIONS	HEALTH CARE PROVIDER	ORDER	COMMENTS
PRESCRIPTION MEDICATIONS						
OTC MEDICATIONS						
Acetic Acid Solution	Otic (liquid)	Per label instructions	PRN – Swimmers ear	Yes	No	
Anti acid (Mylanta or Tums)	PO (pills or liquid)	Per label instruction by age/weight	Q 2-4 hrs PRN-Gas, heartburn, indigestion, stomach upset	Yes	No	
Antifungal cream/ spray/ powder	Topical (cream, spray, powder)	Per label instructions	PRN Athletes foot, jock itch	Yes	No	
Antiseptics (Alcohol, Peroxide, Dermal scrub, Bacitracin)	Topical (cream or liquid)	Per label instructions	PRN-Stings/bites, cuts, scrapes, splinters, blisters	Yes	No	
Benadryl/ Diphenhydramine HCL 25 mg/Claritin	PO (elixir, chewable tabs or pills)	Per label instruction by age/weight	Q 6 hrs PRN for allergic reaction (hives, insect bite)	Yes	No	
Caladryl, Calagel, Calamine and Hydrocortisone	Topical (cream or gel)	Per label instructions	Q 6-8 hrs PRN Rash, skin irritation, insect bites	Yes	No	
Cooling gel and Aloe	Topical (cream or gel)	Per label instructions	PRN Burns, sunburn, wind burn	Yes	No	
Cough drops, throat lozenges, Chloraseptic throat spray	PO (lozenges, spray)	Per label instruction by age/weight	PRN Cough, sore throats	Yes	No	
Delsym/ Robitussin/ Robitussin DM	PO (liquid)	Per label instruction by age/weight	Q 4-6 hrs PRN Coughs	Yes	No	
Dimetapp	PO (elixir or tabs)	Per label instruction by age/weight	Q 6-8 hrs for nasal congestion/ drainage	Yes	No	
Ear Care	Topical (liquid)	Per label instructions	Q 6 hrs PRN Pierced ear infections	Yes	No	
Ivy Block and Tecnu	Topical (cream)	Per label instructions	Q 4 hrs PRN Contact with poison ivy	Yes	No	
Lysine	PO (Chewable tabs, pills or liquid)	Per label instruction by age/weight	Q 4-6 hrs PRN Pain, fever, cold symptoms, toothache, muscle aches	Yes	No	
Motrin / Ibuprofen	PO (Chewable tabs, pills or liquid)	Per label instruction by age/weight	Q 4-6 hrs PRN – Pain, fever, cold symptoms, toothache, muscle aches	Yes	No	
Muscle rub	Topical (cream)	Per label instructions	PRN Minor muscle strains or pains	Yes	No	
Orasol, Anbesol and Abreva	Topical (liquid or cream)	Per label instructions	Q 6 hrs PRN – Oral herpes, cold sores, toothache	Yes	No	
Pepto-Bismol	PO (liquid or chewable tabs)	Per label instructions	Q 30 minutes to 1 hr PRN for diarrhea (no >8 doses/24 hours)	Yes	No	
Pseudoephedrine	PO (Chewable tabs, pills or liquid)	Per label instruction by age/weight	Q 4-6 hrs PRN – Nasal/sinus congestion, hay fever, allergies	Yes	No	
Tylenol	PO (Chewable tabs, pills or liquid)	Per label instruction by age/weight	Q 4-6 hrs PRN – Pain, fever, cold symptoms, toothache, muscle aches	Yes	No	
Visine	Optical (liquid)	Per label instructions	PRN – Eyestrain, eye irritation	Yes	No	