Beaver Camp

Parents: Please make note that the health form is due accurately completed in full, along with any remaining balance **two weeks before** your child's camp start date. Read the Note to Parents on page 4 and be sure to submit page 3 to your child's medical care provider if you want your child to have the availability to receive over-the-counter meds such as Tylenol. Parent and Camper's signatures are required on page 2. If there are questions please call the office at 315-376-2640.

Health Form

ALL PAGES MUST BE COMPLETELY FILLED IN BY PARENT/GUARDIAN OR BY ADULT CAMPER/STAFF

NAME_____ SEX _____ AGE_____

ADDRESS _____CITY_____ST____ BIRTHDATE_____

PARENT(S)/GUARDIAN(S) _____

PHONE: PRIMARY (___)_____ SECONDARY (___)_____ OTHER: (___)_____
IF UNABLE TO CONTACT PARENT/GUARDIAN IN AN EMERGENCY PLEASE CONTACT:

1. NAME _____ PHONE: HOME (___)_____ WORK (___)_____

2. NAME _____ PHONE: HOME (___)_____ WORK (___)_____

FAMILY DOCTOR _____ PHONE (___)_____

MEDICAL INSURANCE _____ POLICY # _____

IMMUNIZATION HISTORY

NEW YORK STATE DEPARTMENT OF HEALTH REQUIRES THAT THE CURRENT IMMUNIZATION HISTORY IS ON RECORD FOR EACH CAMPER AND STAFF **(note: immunizations are NOT required, simply a current record).**

VACCINE:	DTP	Polio	HiB	Prevnar	MMR	Hep. B	Hep. A	Chicken Pox	Rotavirus
List	____	____	____	____	____	____	____	____	____
Dates:	____	____	____	____	____	____		____	____
(month &	____	____	____	____		____			____
year)	____	____	____	____					
	____								

HEALTH HISTORY

Please provide information about your child's **physical, emotional, behavioral or mental health** that camp should be made aware of. Indicate **any dietary or activity restrictions** or ☐ **N/A.** Use additional pages if needed: _____

_____

_____

_____

_____

CHECK If THERE IS A HISTORY OF ANY OF THE FOLLOWING or mark ☐**N/A.**

☐ FREQUENT EAR INFECTION ☐ HEART DEFECT/DISEASE ☐ CONVULSIONS ☐ DIABETES
☐ BLEEDING/CLOTTING DISORDER ☐ HYPERTENSION ☐ MONONUCLEOSIS ☐ ASTHMA

ALLERGIES: Please list all known allergies (medication, food and other) or ☐ **N/A.**

_____

_____

_____

_____

CAMPER NAME (Last, First): _____ **CAMP** _____ **WEEK** _____ **YEAR** _____

PARENT or GUARDIAN AUTHORIZATIONS

(All Campers & Staff) **PERMISSION TO TREAT** **Parent/Guardian's Initial ____**

This history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted. The Beaver Camp administrators, program directors, health director, or their designees are authorized to act in my/our behalf in authorizing unexpected illness, medical, dental, surgical care and hospitalization for the above named minor during their stay at Beaver Camp. This document shall be presented to the Emergency Room staff authorizing consent to treat the above minor. I understand that Beaver Camp will notify me when such care is needed in a timely manner.

(Bear and Teen resident Camps and ALL Wilderness/Outpost Camps)*

OFF-SITE SWIMMING AUTHORIZATION **Parent/Guardian's Initial ____**

Campers in the above mentioned camps* may swim at locations other than Beaver Camp's beach (including Loons optional morning swim). I am aware that my child may be swimming in areas that may not be approved for swimming by a NYS permit-issuing official and that qualified camp staff will determine the suitability of the weather and water conditions at the time of each use. I give permission for my child to swim at such locations, furthermore, I understand that the location may be remote or inaccessible to allow for prompt transfer to an emergency medical health care facility should it be needed.

STAFF ONLY **Parent *(if staff is under 18)*/ or Staff Initial ____**

I do not take any medication that might impair my ability to perform the essential functions of my job at camp this summer. If so I will discuss with the Camp Director and Medical Director immediately.

(ALL CAMPERS and STAFF) **ASSUMPTION OF RISK, RELEASE AND INDEMNIFICATION**

I, the undersigned, recognize that camping can be dangerous and to minimize the risk of injury to myself and others, I agree as follows:

1. I will accept and abide by the rules of Beaver Camp and the Adirondack Mennonite Camping Association. I understand that showing disrespect to other people, property or camp rules may result in me being sent home early and that no refunds will be issued.
2. I will take great care to protect myself and others from injury.
3. In consideration of my opportunity to stay at Beaver Camp and to participate in the activities of the Adirondack Mennonite Camping Association, I:
   - A. Acknowledge that I am responsible for my own safety and Beaver Camp is not responsible for my safety beyond ordinary standards.
   - B. Release and discharge Beaver Camp from any liability arising from my own neglect or carelessness.
   - C. Accept all responsibility for risks within my control.
   - D. Hold harmless and indemnify Beaver Camp from all liability not covered by available liability insurance arising from my participation as a camper and resort to my personal medical, accident and property insurance as my exclusive remedy if available liability insurance is insufficient compensation for my injuries or for damage to my property.
4. For the purpose of this document, Beaver Camp shall include the Adirondack Mennonite Camping Association, its officers, directors, employees and affiliate churches.
5. This Assumption of Risk and Release is binding upon the undersigned, my heirs, distributes, personal representatives and assigns.
6. I give permission for my child to use sunscreen and bug repellant.

Camper Signature _____ Date _____

I, the undersigned parent or guardian, consent to the above-named camper's participation in activities at Beaver Camp; I individually and in my representative capacity, join in the foregoing Assumption of Risk and Release. In addition, consent is given that photos and videos which include the above named camper may be used for camp publicity.

Signature of Parent/Guardian _____Witness _____ Date _____

(Required if camper is under 18 years of age.)

MEDICATIONS (for all campers and staff under 18)

All medication (prescription, homeopathic or over-the-counter) must be submitted in original prescription packaging or container to the Health Director at check-in. Aside from emergency medications (such as an Epi-pen or inhaler) your child is not allowed to keep any medications on their person while at camp.

In order for our staff to give your child over-the-counter medications such as Tylenol on an "as needed" basis, **your child's doctor must complete the following section of this form:**

The following **over-the-counter medications** are available in the Infirmary and will be administered by the camp staff as directed by the child's physician. **The child's physician may also include orders for additional over-the-counter medications you will be supplying (**ie: Claritin, Zyrtec, etc.) **or changes in the script for prescription medications in this space:**

Drug Name	Route	Dosage	Schedule and Indications	Comments
Tylenol (acetaminophen)			Q 4hr prn :	
TUMS (calcium carbonate)				
Advil (ibuprofen)			Q 6-8 hrs prn:	
Benadryl (diphenhydramine)			Q 6 hrs prn:	
Other OTC Meds Below				

Additional Physician Orders (to be implemented by the camp staff; i.e. dressing changes, cast care, etc.):

_____

_____

_____

To Be Completed by Provider Only: Name: _____ Phone # _____

Address: _____ License # _____

Signature: _____ Date: _____

Parents: you may also elect to not have any over-the-counter medications administered to your child by placing your initials below:

_____ I choose NOT to have our physician write orders for my child. I understand that no over-the-counter medications will be administered to my child. If medications are deemed necessary, I will be contacted to make personal arrangements to do so. **PLEASE NOTE:** if your child is attending an off-site adventure trip it is strongly recommended that you have your physician complete the above form due to the remote nature of such trips.

CAMP USE ONLY – HEALTH SCREENING

Prescription Drugs: _____Non Prescription Drugs: _____

Have you been exposed to a communicable disease in the past three weeks? ____

If yes, list disease and date: _____

Any current injuries? ____ If yes, observe and describe: _____

_____

Signed _____

MEDICAL TREATMENT

DATE	TIME	REASON FOR VISIT	TREATMENT	PARENT CONTACTED?	INITIAL

A Note to Parents on preparing for Sunday Check In…

1. Prescription medications must be in original containers with accurate current dosing instructions clearly visible on container. Pack camper's medications in clear zippered bag with camper's name written on it.

2. All non-prescription medications must be in original containers and accompanied by a script or written instructions from health care provider. This includes herbal and homeopathic remedies. These should also be packed in a clear plastic zippered bag with the camper's name clearly written on it.

3. Rescue inhalers may be kept with the camper if they are likely to be needed during activities. Notify the Health Director and counselor/trip leader.

4. Campers that must carry an Epi-Pen for bee sting or other severe allergies should have a waist pack they can use to keep it on their person at all times, except bathing, swimming and sleep.

5. Please have a copy of current immunizations attached to or transcribed onto the Health Form. We cannot use last year's record, even if there are no updates.

6. Please notify camp ahead of time regarding food allergies, therapeutic diets, complex medical conditions, or other health needs which might require prior planning and accommodation.