

# Unirondack Medical Form 2012

## Instructions

This is a fill-in form that can be typed into directly. Because parts of the form require a signature from a parent or guardian or a doctor, it must be printed and mailed after completion, rather than e-mailed. Please mail the completed form, including your **child's immunization record**, to **Unirondack, P.O. Box 795, Nyack, NY 10960 prior to May 1**. If for any reason you cannot complete the form on time (such as a camper who is registering after May 1), please e-mail us at [Director@Unirondack.org](mailto:Director@Unirondack.org) or call the office at 845-675-9001 to make special arrangements.

### PHYSICAL EXAMINATION

There is **NO** requirement for a physical examination for camp. This form should be filled out and signed by a parent/guardian. The only page that requires a doctor's signature is the Individualized Medical Orders on page 4, giving us permission to administer medicine, including over the counter medicine.

### FAMILY AND CAMPER INFORMATION

Please complete all sections. It is important that we be able to contact you in the event of an emergency. We strongly urge you to share any pertinent information about your child if they have special needs. This allows us to advise you about our ability to meet your child's needs and greatly increases the probability that their experience at camp will be a positive one.

### INSURANCE DETAILS

Please fill in the health insurance information and **attach a photocopy of your health insurance card**.

### EMERGENCY CONTACT DETAILS

These contacts should be extended family members or trusted friends who you would like us to contact in an emergency in the event that we cannot reach you. Please make certain to check the box indicating whether or not you are authorizing the emergency contact to make decisions about your child's medical care in the event that you cannot be reached. If they are people who are likely to know your whereabouts that is especially helpful.

### MEDICAL ORDERS and IMMUNIZATION RECORD

Please have your **doctor** fill out and **sign** the medical orders, which allow us to administer medicine to your child. Also, please obtain your child's **immunization record and attach it to this form**.

### MENINGITIS VACCINATION

Please read and check the appropriate box and **sign**.

### DECLARATION

Please read and **sign** the declaration at the end of the form. Thank you.

# Unirondack Medical Form 2012

## CHECKLIST

**Page 1** Camper/Family Info and Emergency Contacts

*(To Be Filled Out By Parent)*

**Page 2** Medical Conditions, Physician and Insurance Information *(To Be Filled Out By Parent)*

**Page 3** Signed Declaration *(To Be Filled Out and Signed By Parent)*

**Page 4** Medical Orders *(Include details of prescription medications to be dispensed at camp) (To Be Filled Out and Signed by Doctor)*

**Copy of Insurance Card** *(Attached)*

**Copy of Immunization Record** *(Attached)*

**PLEASE INCLUDE THE COMPLETED FORM WITH YOUR REGISTRATION (**NOTE:** Page 4 can be sent separately by May 1 if more convenient)**

# Unirondack Medical Form 2012 (page 1)

Mail all 4 pages of form and immunization record and copy of insurance card to:  
**Unirondack, P.O. Box 795 Nyack, NY 10960**

## CAMPER INFORMATION

Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Age at Camp: \_\_\_\_\_ Sex: \_\_\_\_\_ Weight: \_\_\_\_\_

Registered for Session(s): \_\_\_\_\_

## FAMILY INFORMATION

Parent/Guardian: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Address: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Address: \_\_\_\_\_

## EMERGENCY CONTACTS

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

\_\_\_\_ I authorize this person to make medical decisions on behalf of my child in the event that I cannot be reached.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

\_\_\_\_ I authorize this person to make medical decisions on behalf of my child in the event that I cannot be reached.

# Unirondack Medical Form 2012 (page 2)

Camper Name \_\_\_\_\_

## MEDICAL CONDITIONS, LIMITATIONS, ALLERGIES

Please answer YES or NO:

Asthma \_\_\_\_\_ Diabetes \_\_\_\_\_ Seizures \_\_\_\_\_ Bleeding/Clotting \_\_\_\_\_ Heart Disease \_\_\_\_\_

Please list any other Conditions, Limitations, or Medications your child takes:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Dietary Requirements: Vegetarian \_\_\_\_\_ Vegan \_\_\_\_\_ Other \_\_\_\_\_

Allergies to foods/Special Requirements \_\_\_\_\_

**Special Needs** (Please describe any emotional, behavioral, physical or other special needs or conditions. Include any situations of stress or special changes in your household.):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## PRIMARY PHYSICIAN INFORMATION

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

OTHER TREATMENT PROFESSIONALS: \_\_\_\_\_

\_\_\_\_\_

## MEDICAL INSURANCE (Please attach a copy of your insurance card to this form!)

Primary Insured: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Group ID: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Insurance Company Phone Number \_\_\_\_\_

\_\_\_\_\_

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Camper Name \_\_\_\_\_

## IMMUNIZATION RECORDS

Please attach a photocopy of your child's immunization records to this form.

The NYS Dept. of Health requires a complete record of all immunizations received prior to attending Unirondack. We require dates of the following Immunizations: **Tetanus, DPT, Polio, Measles, Mumps, Haemophilus Influenza type A, Hepatitis B**, and a vaccine or the date of the following Diseases: **Chicken Pox and German Measles**.

## MENINGITIS VACCINATION

New York State Public Health Law requires that all parents or guardians of residential summer camp campers complete and return the following certification. Check one box and sign below.

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

Date received: \_\_\_\_\_

**(NOTE:** If your child received the meningococcal vaccine available before February 2005 called Menomune, please note the vaccine's protection lasts for approximately 3 to 5 years. Revaccination with the conjugate vaccine Menactra should be considered within 3-5 years after receiving Menomune.)

\_\_\_ I have read, or have had explained to me, the information regarding meningococcal meningitis disease. My child will obtain immunization against meningococcal meningitis within 30 days from my private health care provider.

\_\_\_ 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: \_\_\_\_\_

## DECLARATION

I, as parent/guardian of the above named UNIRONDACK camper, do hereby certify that I have accurately listed all known medical conditions, limitations or allergies above. I give my permission to the Director, or the designated Unirondack Healthcare Provider/EMT to authorize emergency medical treatment for this camper if I cannot be reached at the above emergency contact numbers.

I give permission to Unirondack, Inc. to follow the medical orders from Dr. \_\_\_\_\_.

I agree to accept financial responsibility for all medical care provided.

I understand that any medications can only be dispensed if they are handed in at Unirondack in their original container with the physician's instructions printed on it.

I understand that Unirondack will refuse to accept and will send home any camper who has a health, emotional, behavioral or physical needs that can not be handled safely or appropriately at Unirondack.

Name \_\_\_\_\_ Signed \_\_\_\_\_ Date \_\_\_\_\_

**INDIVIDUALIZED MEDICAL ORDERS** *(must be signed by physician)*

Please indicate by circling Yes or No whether the following medications can be administered to the camper at the discretion of the Camp's Healthcare Provider/EMT.

Drug Name	Route (Circle preferred formulations)	Dosage	Schedule and Indications	Healthcare Provider Order	Comments
Pseudoephedrine hydrochloride (Sudafed)	PO (Tablets)	Per label instructions by age/weight	Q 4 hours prn for nasal congestion	<b>Yes</b> <b>No</b>	
Acetaminophen (Tylenol)	PO (chewable tabs, elixir, or tablets)	Per label Instructions by age/weight	Q 4 hours prn for pain or fever	<b>Yes</b> <b>No</b>	
Ibuprofen	PO (chewable tabs, suspension)	Per label instructions by age/weight	Q 6 hours prn for pain or fever	<b>Yes</b> <b>No</b>	
Kaopectate	PO (suspension or tablets)	Per label instructions by age/weight	Q 2 hours prn for diarrhea	<b>Yes</b> <b>No</b>	
Diphenhydramine (Benadryl)	PO (elixir, chewable tabs, suspension, or pills)	Per label instructions by age/weight	Q 6 hours prn for allergic reactions (hives, insect bite)	<b>Yes</b> <b>No</b>	
Robitussin DM	PO (syrup)	Per label instructions by age/weight	Q 4 hours prn for cough	<b>Yes</b> <b>No</b>	
Mylanta/Tums	PO (chewable tabs)	Per label instructions by age/weight	Q 4 hours prn for stomach upsets	<b>Yes</b> <b>No</b>	
Epinephrine (EpiPen)	IM	Per label instructions 0.3 ml or 0.1 ml	Per NYS DOH protocol for anaphylaxis	<b>Yes</b> <b>No</b>	

Please give details of any prescription/other medications that the camper is currently taking and the camp's healthcare provider will be required to administer (attach copy of prescription if available):

Drug	Route	Dosage	Schedule and Indications	Comments

Additional orders as deemed necessary by physician (dressing changes, cast care, etc):

\_\_\_\_\_

Physician Name (Print) \_\_\_\_\_ Phone \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date \_\_\_\_\_