

Staff Medical Report Summer 2018

David Dweck, LCSW
Director
Diane Anderson, RN

Mailing Address

336 Ave Y
Brooklyn, NY 11223

Camp Location

1750 Brielle Ave, Ocean, N.J. 07712
Tel: W - 718-339-7772, S - 732-660-8020
Fax: 718-504-4263

EMERGENCY CONTACT INFORMATION

STAFF MEMBER'S NAME: LAST, FIRST		DATE OF BIRTH	GRADE 2018
MOTHER'S NAME	SUMMER PHONE	MOTHER'S CELL PHONE	MOTHER'S WORK PHONE
FATHER'S NAME	SUMMER HOME PHONE (IF DIFF'T)	FATHER'S CELL PHONE	FATHER'S WORK PHONE
OTHER CONTACT NAME	SUMMER HOME PHONE	CELL PHONE	RELATIONSHIP TO CAMPER
OTHER CONTACT NAME	SUMMER HOME PHONE	CELL PHONE	RELATIONSHIP TO CAMPER

ALLERGIES Please submit a *separate special care plan* from your physician for any serious allergies, esp. those requiring an EPI pen.

MEDICATION ALLERGIES	PLEASE DESCRIBE REACTION AND MANAGEMENT TO THE REACTION
FOOD ALLERGIES	PLEASE DESCRIBE REACTION AND MANAGEMENT TO THE REACTION
OTHER ALLERGIES	PLEASE DESCRIBE REACTION AND MANAGEMENT TO THE REACTION

MEDICATIONS BEING TAKEN: Please list all medications (including over the counter). If you/your child need to take medication in camp, keep all medication in original packaging that identifies the prescribing physician, the name of medication, the dosage and the frequency. It will be stored and dispensed at the Nurses Office.

MEDICATION #1	MEDICATION #1
DOSAGE	DOSAGE
TIME TAKEN	TIME TAKEN
REASON FOR TAKING	REASON FOR TAKING
PRESCRIBING DOCTOR	PRESCRIBING DOCTOR

I/My child take NO MEDICATION on a routine basis.

I/My child TAKES MEDICATION as follows:

I/ My child takes prescription behavioral medication as follows:

MEDICATION PERMISSION The Camp Nurse has my permission to administer the following over-the-counter medications according to the label instructions.

Acetaminophen (Tylenol) Ibuprofen (Advil) Antibiotic Cream Calamine Lotion
Antihistamine (Benadryl) Sunburn Spray (Solarcaine) Sting Swabs

MEDICAL INSURANCE INFORMATION:

Insurance Company :	Policy Number :
Subscriber name :	Insurance Company Phone :
Parent Authorization for Emergency Treatment and Trip release	
<p>This health and Medical record is correct and accurately reflects the health status of the person to whom it pertains. The person described above has permission to participate in all camp activities except as noted in this form. I understand that part of the camp experience involves activities and interactions that may be new to my child. These come with certain risks and uncertainties beyond those my child may be used to dealing with at home. I am aware of these risks, and I am assuming them on behalf of my child. In the event that I cannot be reached in an emergency, I authorize all medical and surgical treatment, x-ray, laboratory, anesthesia, and other medical and/or hospital procedures as may be performed or prescribed by the attending physician for my child and waive my right to informed consent of treatment. I understand that the information on this form will be shared on a 'need to know' basis with camp staff. I give permission to photocopy this form for trips out of camp. In addition, the camp has permission to obtain a copy of this person's health record from providers who treat my child, and these providers may talk with program staff about my child's health status. I release Camp Allsport and individuals from liability in case of accident during activities, as long as normal safety procedures have been taken. I give Camp Allsport permission to photograph/video my child during camp for Camp Allsport promotional purposes.</p>	
_____	_____
Parent or legal guardian's signature	Date



STAFF PHYSICAL EXAMINATION FORM 2018

STAFF MEMBER'S NAME: LAST, FIRST	DATE OF BIRTH	GRADE 2018
---	----------------------	-------------------

PHYSICAL EXAMINATION (MUST BE FILLED OUT BY A LICENSED PHYSICIAN)

In my opinion, the above staff member is is not able to participate in all camp programs.

Height _____ Weight _____ BP _____

Glasses yes no Contact lenses yes no

Which of the following has the staff member had?

Measles Hepatitis A Hepatitis B Hepatitis C Mumps German Measles Chicken Pox

MEDICATION PERMISSION The Camp Nurse has my permission to administer the over-the-counter medications according to the label instructions.

Please attach a copy of the patient's immunization record

Doctor's signature & stamp

Date

This completed form may be faxed back to Camp Allsport at 1-78-504-4263 or e-mailed (in attachment form)
to nurse@campallsport.com