David Dweck, LCSW
Director
Diane Anderson, RN

Staff Medical Report
Summer 2021

Winter Address
1122 Avenue J
Brooklyn, NY 11230
Camp Location
235 Hope Rd. Tinton Falls, NJ, 07724
Tel: W:718-339-7772 S:732-660-8020
Fax: 718-504-4263

EMERGENCY CONTACT INFORMATION

Staffs NAME: LAST, FIRST		Staff'S DATE OF BIRTH	GRADE 2021
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 STAFF
OTHER CONTACT NAME	SUMMER HOME PHONE	CELL PHONE	RELATIONSHIP TO STAFF

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 your child needs 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

□ My child takes NO MEDICATION on a routine basis.
□ My child TAKES MEDICATION as follows:
□ 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, at their discretion: Please *initial* all that apply:

☐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 :

OTHER INFORMATION:

List any restrictions from Camp activities:	Special Dietary needs/food restrictions:

Any additional information about your child's behavior, physical, emotional or mental health that we should be aware of:

Parent Authorization for Emergency Treatment and Trip release
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.
_____ Parent or legal guardian's signature _____ Date

CAMPER'S NAME: LAST, FIRST	CAMPER'S DATE OF BIRTH	GRADE 2021

PHYSICAL EXAMINATION - TO BE FILLED OUT BY LICENSED PHYSICIAN

I examined this individual on _____. In my opinion, the above camper □ 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

Name of Physician:	Phone:
Signature of Physician:	**Date:**
Name of Dentist/orthodontist:	Phone

MEDICATION PERMISSION: The camp nurse has my permission to administer the over-the-counter medications according to label instruction.

PLEASE ATTACH A COPY OF PATIENT'S IMMUNIZATION RECORD

Please fax completed form to 718-504-4263 or scan and email them to Nurse@campallsport.com
Do Not Mail!