



# 2018 Medical Information for Southwoods Camp

Please return this medical packet to the Southwoods Office by May 1st.

The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care. Health history must be filled out by the parents/guardians of minors or by adults themselves. Updates are required annually. The Health exam must be completed by approved licensed medical personnel every year.

*Southwoods*

**Circle Session:**    Session 1 (June 24 – July 19)    Session 2 (July 22 – August 16)

**First Name:** \_\_\_\_\_ **Last Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Current Grade:** \_\_\_\_\_ **School:** \_\_\_\_\_ **Gender (circle):** Female Male

**Street Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Summer Phone:** \_\_\_\_\_

**Guardian/Parent Name:** \_\_\_\_\_ **Cell #:** \_\_\_\_\_ **Work #:** \_\_\_\_\_

**Guardian/Parent Name:** \_\_\_\_\_ **Cell #:** \_\_\_\_\_ **Work #:** \_\_\_\_\_

**If parent/guardian is not available in an emergency, please notify:** \_\_\_\_\_ **Relation to child:** \_\_\_\_\_

**Home #:** \_\_\_\_\_ **Cell#:** \_\_\_\_\_ **Work #:** \_\_\_\_\_

## \*IMPORTANT – THIS BOX MUST BE COMPLETE FOR ATTENDENCE

The health history is correct and complete as far as I know. The person herein named has permission to engage in all activities except as noted.

I hereby give permission to the camp to provide, seek, and consent to routine health care, the administration of sunscreen, the administration of bug repellent, prescribed medications, and emergency treatment for my child, as may be necessary, including, but not limited to x-rays, routine tests and treatment, and/or hospitalization. I also give permission for the camp to arrange related transportation. I agree to the release of any records necessary for the treatment, referral, billing or insurance purposes.

It is my intention that the camp be treated as acting in *loco parentis* if the person herein named is a minor. Further, it is my intention that the appropriate representatives of the camp be treated as “personal representatives” for the purpose of disclosing protected health information pursuant to the privacy regulations promulgated pursuant to the Health Insurance Portability Act of 1996. I hereby agree (pursuant to 45 CFR, 164.510(b)) to the disclosure to camp representatives of the protected health information of the person herein described, as necessary: (i) to provide relevant information to the camp representatives related to the persons ability to participate in camp activities; and (ii) in the case of minors, to provide relevant information to the camp representatives to keep me informed of my child’s health status.

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

**Signature of Parent /Guardian:** \_\_\_\_\_

**Printed Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

# Southwoods Camper Insurance Information – Choose Option Below

Camper's Full Name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

## Option 1: Private Insurance

This option is only available to domestic families. All co-pay bills will be sent to the address above.

**\*A photocopy of the front and back of the health insurance card must be attached to this form.**

- Name of Parent/Guardian through whom the group or family plan is written:

\_\_\_\_\_

- Name of Insurance Company that underwrites your group or family plan:

\_\_\_\_\_

- Name of Company (where employed) which enrolls your family, if in a group plan:

\_\_\_\_\_

Group Number: \_\_\_\_\_ ID Number: \_\_\_\_\_ RX Bin#(Required): \_\_\_\_\_

Plan: \_\_\_\_\_ Type: \_\_\_\_\_ Effective Date: \_\_\_\_\_

## Option 2: Southwoods Insurance

**All international families must choose this plan.**

You may also choose this plan if you do not carry a Hospital/Medical Insurance Policy for your family or if you wish to complement your family policy.

\* Please send a check for \$150 to the Southwoods Office, or we can charge a credit card on file.

The insured camper will receive the following:

Coverage for each accident, up to a maximum \$5,000

Coverage for each illness, up to a maximum \$5,000

Coverage for accidental death, \$7,500

*Coverage is in effect for up to 26 weeks following each accident/illness for necessary hospital, medical, surgical care, services and supplies such as prescription medications, x-rays and nursing.*

Initial here \_\_\_\_\_ to enroll your camper in the Southwoods Camper Accident/Illness Plan for the charge of \$150.

### Confirm the insurance coverage option you would like:

Option 1: Private Insurance

Option 2: Southwoods Insurance

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Health History

The following information must be filled in by the parent/guardian, or adult camper/staff member. The intent of this information is to provide camp health care personnel the background to provide appropriate care. Keep a copy of the completed form for your records. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp. Provide complete information so that the camp can be aware of your needs.

## Allergies (Medication, Food, etc)

## Describe reaction and management of the reaction

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

## Other allergies (include insect stings, hay fever, asthma, animal dander, etc.)

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

## Dietary RESTRICTIONS:

The following restrictions apply to this individual. Please check all that apply.

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Does not eat red meat | <input type="checkbox"/> Does not eat pork    | <input type="checkbox"/> Does not eat eggs           |
| <input type="checkbox"/> Does not eat poultry  | <input type="checkbox"/> Does not eat seafood | <input type="checkbox"/> Does not eat dairy products |
| <input type="checkbox"/> Gluten free diet      | <input type="checkbox"/> Vegetarian diet      | <input type="checkbox"/> Other (describe below)      |

Notes: \_\_\_\_\_  
\_\_\_\_\_

## Activity Based RESTRICTIONS:

Please describe in detail what can or cannot be done, and what adaptations or limitations are necessary.

_____
_____
_____

# Medications Being Taken

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Medications other than injectables, inhalers and liquids must come to camp via CampPacks. All injectables, inhalers and liquids must arrive at camp prior to camper arrival date for the infirmary staff to process. Please do not send non-routine over the counter medication to camp. If your child takes an over the counter medication on a routine basis then that medication must go through CampPacks. All other over the counter medication will be provided by Southwoods.

\_\_\_\_\_ **This person takes NO medications on a routine basis**

\_\_\_\_\_ **This person takes the medications as follows:**

**Med #1** \_\_\_\_\_ Dosage \_\_\_\_\_ Daily Time Taken \_\_\_\_\_

Reason for taking \_\_\_\_\_

**Med #2** \_\_\_\_\_ Dosage \_\_\_\_\_ Daily Time Taken \_\_\_\_\_

Reason for taking \_\_\_\_\_

**Med #3** \_\_\_\_\_ Dosage \_\_\_\_\_ Daily Time Taken \_\_\_\_\_

Reason for taking \_\_\_\_\_

*Attach additional pages for more medications.*

Identify any medications taken during the school year that participant does/may not take during the summer:

\_\_\_\_\_

**Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which the camp should be aware.**

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

Name of family physician: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Name of family dentist/orthodontist: \_\_\_\_\_ Phone: \_\_\_\_\_

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



# Health Care Recommendations by Licensed Medical Personnel

I examined this individual on \_\_\_\_\_ . (Date must be within one year of your camper's session start date)

BP \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_

In my opinion, the above applicant \_\_\_ is \_\_\_ is not able to participate in an active camp program.

The applicant is under the care of a physician for the following conditions:

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## Recommendations and Restrictions at Camp

Treatment to be continued at camp \_\_\_\_\_

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Medications to be administered at camp (name, dosage, frequency) \_\_\_\_\_

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Any medically – prescribed meal plan or dietary restrictions \_\_\_\_\_

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Known allergies \_\_\_\_\_

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Description of any limitation or restriction on camp activities \_\_\_\_\_

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Additional information for health care staff at camp \_\_\_\_\_

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Signature of Licensed Medical Personnel \_\_\_\_\_

Printed \_\_\_\_\_ Title \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Date \_\_\_\_\_

# MENINGOCOCCAL MENINGITIS VACCINATION RESPONSE FORM

Before completing this page, please review the included letter and information about Meningitis.

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 for seven (7) or more nights.

**Camper's Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Circle Session:**            Session 1            Session 2

## Check one box and sign below:

- My child has had the meningococcal meningitis immunization (Menomune™) within the past 10 years.  
Date received: \_\_\_\_\_  
*Note: The vaccine's protection lasts for approximately 3 to 5 years. Revaccination may be considered within 3-5 years.*
- 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.
- My child will be receiving the immunization at a later date.

**Printed Name of Parent / Guardian:** \_\_\_\_\_

**Signature of Parent / Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_

