

For Office  
Use

**DIRECTORS:**  
Debbi & Paul Schorey  
www.chestnutlakecamp.com

# Chestnut Lake Camp

**SUMMER ADDRESS:**  
PO Box 369  
Beach Lake, PA 18405  
Phone: 570-729-1010  
Fax: 570-729-8883  
**WINTER ADDRESS:**  
1714 Wantagh Avenue  
Wantagh, NY 11793  
Phone: 516-221-8800  
Fax: 516-221-4350

## 2010 Camper Medical Form

Year

Name \_\_\_\_\_ Birth date \_\_\_\_\_ Age at camp \_\_\_\_\_

Home address \_\_\_\_\_

Social security number of camper \_\_\_\_\_ Gender:  Male  Female

Custodial parent/guardian \_\_\_\_\_ Phone \_\_\_\_\_

Mobile \_\_\_\_\_

Second parent/guardian \_\_\_\_\_ Phone \_\_\_\_\_

Mobile \_\_\_\_\_

**If not available in an emergency, notify:**

Name \_\_\_\_\_

Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Group

**Important—This box must be completed for attendance**

Parent/Guardian Authorizations: This health history is correct and complete as far as I know. The camper herein described has permission to engage in all camp activities except as noted.

I hereby give permission to the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I authorize any physician, nurse or other health care provider, to communicate with the medical staff and director of Trail's End Camp, or his/her designee, about my child's medical condition, treatment, and/or prognosis. I further authorize the camp medical staff to discuss any medical

conditions with the director, his/her designee, or the child's counselor when the medical staff, in its sole discretion, believes such communication to be in the best interest of the child. I agree to the release of any records necessary for insurance purposes. I give permission to the camp to arrange necessary related transportation for my child.

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by 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 \_\_\_\_\_

Name

## Insurance Information

**In the event your child will need prescription or treatment at the local hospital, it is imperative that we have your insurance information and credit card information. Please attach copies of insurance/drug cards to the medical form.**

### Medical Insurance Information:

Name of Insurance Company \_\_\_\_\_

Address \_\_\_\_\_

Group Number \_\_\_\_\_

Policy Number \_\_\_\_\_

### Drug Insurance Information:

Name of Insurance Company \_\_\_\_\_

Address \_\_\_\_\_

Group Number \_\_\_\_\_

Policy Number \_\_\_\_\_

Please note that we need you to attach to the medical form a copy of your insurance/drug card. We will need this information in the unlikely event that your child has to be treated at the local hospital or needs prescription medication.

**Attach a copy of the Insurance Card here:**

Front:

Back:

**Attach a copy of the Drug Card here:**

Front:

Back:

**In the unlikely event that the pharmacy/doctor does not accept your medical/drug card, I hereby authorize Chestnut Lake Camp to use the following credit card for purposes of paying for such charges.**

**Name on card:** \_\_\_\_\_ **Amex | Visa | Mastercard (Circle one)**

**Card Number:** \_\_\_\_\_ **Expiration date:** \_\_\_\_\_

# Health History

The following information must be filled in by the parent or guardian of the camper. 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 camper's arrival at camp. Provide complete information so that the camp can be aware of your needs.

### Allergies (list all known)

### Describe reaction and management of the reaction.

Medication allergies (list)

_____	_____
_____	_____
_____	_____

Food allergies (list)

_____	_____
_____	_____

Other allergies (list)—including insect stings, hay fever, asthma, animal dander, etc.

_____	_____
_____	_____

### Medications Being Taken

This camper takes NO medication on a routine basis.

This camper takes medications as follows:

Med #1 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_  
Reason for taking \_\_\_\_\_

Med #2 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_  
Reason for taking \_\_\_\_\_

Med #3 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_  
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: \_\_\_\_\_  
\_\_\_\_\_

### Restrictions

The following restrictions apply to this staff member:

#### Dietary

- Does not eat red meat
- Does not eat eggs
- Does not eat poultry
- Does not eat dairy products
- Other (describe) \_\_\_\_\_

Explain any restrictions to activity (e.g., what cannot be done, what adaptations or limitations are necessary).

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

**General Questions** (Explain “yes” answers below.)

Has/does the camper:	Yes	No		Yes	No
1. Had any recent injury, illness or infectious disease?	<input type="radio"/>	<input type="radio"/>	16. Ever had back problems?	<input type="radio"/>	<input type="radio"/>
2. Have a chronic or recurring illness/condition?	<input type="radio"/>	<input type="radio"/>	17. Ever had problems with joints (e.g., knees, ankles)?	<input type="radio"/>	<input type="radio"/>
3. Ever been hospitalized?	<input type="radio"/>	<input type="radio"/>	18. Have an orthodontic appliance being brought to camp?	<input type="radio"/>	<input type="radio"/>
4. Ever had surgery?	<input type="radio"/>	<input type="radio"/>	19. Have any skin problems (e.g., itching, rash, acne)?	<input type="radio"/>	<input type="radio"/>
5. Have frequent headaches?	<input type="radio"/>	<input type="radio"/>	20. Have diabetes?	<input type="radio"/>	<input type="radio"/>
6. Ever had a head injury?	<input type="radio"/>	<input type="radio"/>	21. Have asthma?	<input type="radio"/>	<input type="radio"/>
7. Ever been knocked unconscious?	<input type="radio"/>	<input type="radio"/>	22. Had mononucleosis in the past 12 months?	<input type="radio"/>	<input type="radio"/>
8. Wear glasses, contacts or protective eye wear?	<input type="radio"/>	<input type="radio"/>	23. Had problems with diarrhea/constipation?	<input type="radio"/>	<input type="radio"/>
9. Ever had frequent ear infections?	<input type="radio"/>	<input type="radio"/>	24. Have problems with sleepwalking?	<input type="radio"/>	<input type="radio"/>
10. Ever passed out during or after exercise?	<input type="radio"/>	<input type="radio"/>	25. If female, have an abnormal menstrual history?	<input type="radio"/>	<input type="radio"/>
11. Ever been dizzy during or after exercise?	<input type="radio"/>	<input type="radio"/>	26. Have a history of bed-wetting?	<input type="radio"/>	<input type="radio"/>
12. Ever had seizures?	<input type="radio"/>	<input type="radio"/>	27. Ever had an eating disorder?	<input type="radio"/>	<input type="radio"/>
13. Ever had chest pain during or after exercise?	<input type="radio"/>	<input type="radio"/>	28. Ever had emotional difficulties for which professional help was sought?	<input type="radio"/>	<input type="radio"/>
14. Ever had high blood pressure?	<input type="radio"/>	<input type="radio"/>			
15. Ever been diagnosed with a heart murmur?	<input type="radio"/>	<input type="radio"/>			

Please explain any “yes” answers, noting the number(s) of the question(s).

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Which of the following has the camper had?

- Measles
- Chicken pox
- German measles
- Mumps
- Hepatitis A
- Hepatitis B
- Hepatitis C
- TB Mantoux Test

Please give all dates of immunization for:

Vaccine:	Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP		_____	_____	_____	_____	_____	_____
TD (tetanus/diphtheria)		_____	_____	_____	_____	_____	_____
Tetanus		_____	_____	_____	_____	_____	_____
Polio		_____	_____	_____	_____	_____	_____
MMR		_____	_____	_____	_____	_____	_____
or Measles		_____	_____	_____	_____	_____	_____
or Mumps		_____	_____	_____	_____	_____	_____
or Rubella		_____	_____	_____	_____	_____	_____
Haemophilus influenza B		_____	_____	_____	_____	_____	_____
Hepatitis B		_____	_____	_____	_____	_____	_____
Varicella (chicken pox)		_____	_____	_____	_____	_____	_____

Date of last test \_\_\_\_\_

Result:  Positive  Negative

**Use this space to provide any additional information about the camper’s behavior and physical, emotional or mental health about which the camp doctors/nurses should be aware.**

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

Address \_\_\_\_\_

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

Address \_\_\_\_\_

# Health Care Recommendations to be Completed by Family Physician

I examined \_\_\_\_\_ on \_\_\_\_\_  
(name) (date)

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

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

The camper 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 the camp

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<b>Signature of licensed medical personnel</b> _____	
Printed _____	Title _____
Address _____	
Phone _____	Date _____