



# Camp Hickory Hill Health Form

2970 Kohler Rd.  
Varysburg, NY 14167  
(585) 535-7832



CABIN:

EXAM DATE:

CAMP WEEK:

NAME:

This form **MUST** be accurately completed for all campers and staff, and must be submitted at least two weeks prior to attending camp. **Part One** should be filled out by the camper's parents. **Part Two** must be filled out by your personal care physician, physician's assistant or certified nurse practitioner. Camp Hickory Hill is located on a hillside and will be physically challenging if your child's mobility is limited or health is otherwise impaired. Please be certain your child is in good health and up to the physical demands upon arrival at camp. We will be unable to safely accommodate some types of medical conditions. Please contact the camp director if you have questions regarding this.

## PART ONE

Please be advised that we are subject to New York State laws and require the EXACT information requested. Failure to document this information will result in delay of registration of your camper.

Name \_\_\_\_\_ Gender \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_

### PERSON TO CONTACT IN CASE OF EMERGENCY:

Name \_\_\_\_\_ Relationship to camper \_\_\_\_\_ Phone \_\_\_\_\_  
Name \_\_\_\_\_ Relationship to camper \_\_\_\_\_ Phone \_\_\_\_\_

### Health Insurance Information:

Carrier \_\_\_\_\_ Type \_\_\_\_\_  
Policy # \_\_\_\_\_ Phone # ( ) \_\_\_\_\_  
In Whose Name? \_\_\_\_\_

**IMMUNIZATIONS** - We must have dates (month/year). It is not sufficient to write "Up-to-date." It is sufficient to attach a copy of immunizations provided by the camper's medical care provider. If no immunizations have been given, we must have documentation attached.

DPT Series \_\_\_\_\_ Tetanus \_\_\_\_\_ Polio OPV (Sabin) \_\_\_\_\_  
German Measles \_\_\_\_\_ Measles Vaccine (live) \_\_\_\_\_ Mumps \_\_\_\_\_ Hepatitis B \_\_\_\_\_  
TB Test (latest) \_\_\_\_\_ Results \_\_\_\_\_ Hib \_\_\_\_\_ Varicella Chicken Pox \_\_\_\_\_

**Health History:** (check all that apply) Diabetes \_ Rheumatic Fever \_ Bedwetting \_ Ear Infection \_  
Convulsions \_ Sleep Walking \_ Communicable or contagious illnesses \_ Other \_\_\_\_\_

Please share any further comments regarding your child's social, emotional, and/or psychological well-being that would be important for the staff to be aware of. (This information will only be shared with the pastors, directors and your child's specific counselor for the safety and well-being of the campers.) \_\_\_\_\_

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

Parent's Authorization (must be signed): This health form is correct so far as I know, **and the person herein described has permission to engage in all camp activities (climbing wall, archery, riflery, canoeing, fishing, swimming, hiking, sports, crafts, etc.), except as noted on this form.** In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for my child as named above. I also authorize the camp nurse to administer treatment as per standing order protocol and to administer any medications prescribed by his/her physician as listed on this form.

Parent/Guardian Signature \_\_\_\_\_ Relationship \_\_\_\_\_ Date \_\_\_\_\_

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

**PART TWO**

**Dear Health Care Provider,**

Your patient - \_\_\_\_\_ will be attending Camp Hickory Hill as a camper or staff member. There will be a Camp Health Director at camp during the week to provide for any health care needs of all campers. In addition to the use of basic medical supplies to provide for general health care, the Camp Health Director is able to consult with an area M.D., P.A. or C.N.P. should the need arise. Your office and the camper's parents would also be contacted should the situation warrant. There is a local hospital approximately 15 miles away where emergency services are available at all times. Please review the following general prn orders, deleting (by crossing out and initialing) or adding any additional OTC or prescription medications. Your signature at the bottom will authorize the Camp Health Director to administer treatment should your patient require general health care during his/her week at camp. (The Camp Health Director meets all certification standards according to the New York State Sanitary Code for Overnight Camps – He or she is typically an RN, but may be an EMT, LPN, MD, PA or CNP.)

**Orders for Camp Nursing Care**

**Hay Fever Allergy Symptoms:** Benadryl q 4-6 hours prn according to directions on bottle for age/weight of child Or Loratidine (Claritin) 10 mg. q 24 hours prn for adults and children over 6 years of age. \_\_\_\_\_

**Headache/Mild Pain:** Tylenol q 4-6 hours per dosing instruction prn **OR** Ibuprofen per dosing instruction. \_\_\_\_\_

**Bee Sting without reaction:** Remove stinger, apply ice. Give Tylenol prn for pain per dosing instruction, Benadryl, prn for itching per dosing instruction. Observe for signs and symptoms of swelling which continues to spread more than 24 hours or hives develop – in which case: contact Camp Nurse Practitioner. **If there are multiple bee stings (8-10) contact primary physician and/or take child to ER.** \_\_\_\_\_

**Bee Sting WITH anaphylactic reaction (or ANY ANAPHYLACTIC REACTION):** Give epinephrine (bee sting kit) and call 911 immediately. \_\_\_\_\_

**Skin Abrasions/Lacerations:** Cleanse with soap and water or saline. Use Hydrogen Peroxide. Apply triple antibiotic ointment and a dry sterile dressing. Watch for infection and uncontrolled bleeding. \_\_\_\_\_

**Limb trauma injuries:** Apply ice. Tylenol or Ibuprofen per dosing instruction prn for pain. \_\_\_\_\_

**Contact Dermatitis/Skin Allergies:** Apply hydrocortisone cream t.i.d. per dosing instruction. Cool soaks. Avoid contact with allergen. \_\_\_\_\_

**Head Lice:** Camper suspected to have head lice may be treated with an over-the-counter pediculocide (ie. RID, Nix, etc.) according to packaging directions. Nurse may determine that camper with head lice infestation should be sent home for treatment. \_\_\_\_\_

**Poison Ivy:** Wash with cool water repeatedly, discarding all clothes that may have "oil" on them. Apply hydrocortisone tid and give Benadryl per dosing instruction to control itching. If the affected area is greater than 1 cm on the face or near the eyes, call primary physician. \_\_\_\_\_

**Poisoning: Call Poison Control. 1-800-888-7655**

**Nausea and Vomiting:** Assess for dehydration. Offer small amounts of clear liquids less than one ounce at a time. If vomiting continues for more than 4 – 8 hours call primary physician or send child home. \_\_\_\_\_

**Diarrhea:** Assess for dehydration, give clear liquids. Tums may be given for acid indigestion or “over eating.” \_\_\_\_\_

**Fungal-type Skin infections:** Apply Clotrimazole cream to the affected area, bid per dosing instruction. \_\_\_\_\_

**Sore Throat:** Tylenol prn as per dosing instruction on package. Sore throat spray and lozenges, prn per dosing instruction. Give fluids. If fever persists with sore throat call Cis Lyons, CNP.

**Persistent Cough:** Robitussin (Or generic form) prn q 4 – 6 hours per dosing instruction.

**Cold/Sinus symptoms:** Actifed or Dimetapp q 4 – 6 hours, prn. per dosing instruction.

**Fever/Flu symptoms:** Tylenol and or ibuprofen, prn per dosing instruction. Treat other symptoms, e.g. runny nose with Dimetapp or Actifed or cough with Robitussin as per dosing instruction on package. If fever persists, call primary care physician and/or send the child home. \_\_\_\_\_

**Animal Bites:** Cleanse area with soap and water, running over wound. Apply triple antibiotic ointment and dry sterile dressing. Watch for signs and symptoms of spreading infection in next 24 hours. **PRIMARY CONCERN: RABIES STATUS** of animal. Call Wyoming County Community Hospital (786-2233). \_\_\_\_\_

**Burns:** (including sunburn): Apply cool water. Give Tylenol or Ibuprofen prn, for pain per dosing instruction. \_\_\_\_\_

ADDITIONAL PRN MEDICATIONS THAT MAY BE GIVEN

\_\_\_\_\_

MEDICATION RESTRICTIONS:

\_\_\_\_\_

List all Allergies:

Food \_\_\_\_\_ Medications \_\_\_\_\_ Hay Fever \_\_\_\_\_

Insect bites/stings \_\_\_\_\_ Other \_\_\_\_\_

List any food or activity restrictions: \_\_\_\_\_

\_\_\_\_\_

Camper's Name: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_

Please list ALL medications (including over the counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp.

**IMPORTANT!! Keep all medication in the original and current packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.**

Medication	Dosage	Specific times taken each day	Purpose

Camper must keep inhaler with him at all times. (Please check if applies)

Attach additional pages for more medications.

Date of last physical exam: \_\_\_\_\_

Additional information for the health care staff at Camp Hickory Hill pertinent to this registrant:

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

In my opinion, \_\_\_\_\_  is  is not able to participate in an active camp program.  
Camper's Name

**\*Signature of Licensed Medical Personnel (MD, PA, or CNP ONLY)      Date**

*(\*This signature is required for any camper or for any staff member under the age of 19. By signing this form, the MD, PA or CNP is indicating they have read all four pages of this health form.)*

Printed Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

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

*This form is to be accurately completed and submitted no later than 2 weeks prior to attending camp.*