



CAMP HERRLICH DAY CAMP MEDICAL INFORMATION FORM

BOTH SIDES OF THIS FORM MUST BE COMPLETED IN ORDER TO BE ADMITTED INTO CAMP.

Please return fully completed form (both sides) to Camp Herrlich, 101 Deacon Smith Hill Rd, Patterson, NY 12563

This is the only medical information we will have on file. It is important that you complete this form honestly and thoroughly. Each camper MUST have a completed medical form for the CURRENT CAMP YEAR in order to be admitted to camp.

Camper's Last Name _____ First _____ Birth Date _____

Address _____

Father's Name _____ Home Phone _____ Work Phone _____

Cell # _____ Email Address _____

Mother's Name _____ Home Phone _____ Work Phone _____

Cell # _____ Email Address _____

**Please number the above contact numbers 1-6 so we know in which order we should call in case of emergency.*

ALTERNATE EMERGENCY CONTACT INFORMATION You must list persons other than the parents identified above.

Name: _____ Relationship: _____ Phone: (____) _____ - _____

Name: _____ Relationship: _____ Phone: (____) _____ - _____

Physician/Pediatrician _____ Phone: (____) _____ - _____

Orthodontist _____ Phone: (____) _____ - _____

Dentist _____ Phone: (____) _____ - _____

Is your child currently receiving any form of medical treatment or taking any medication? Yes No

If yes, please explain: _____

Name of physician treating for above: _____ Phone: (____) _____ - _____

Please note: Our Health Center keeps in stock the following non-prescription medications:
Benadryl, Tylenol, Robitussin, Calamine Lotion, etc..
YOUR CHILD WILL NOT BE GIVEN THESE OR ANY OTHER MEDICATIONS WITHOUT DOCTOR'S ORDERS

- Health History** (please check all that apply)
- Ear infections
 - Glasses/Contact Lenses
 - Heart Disease/Defect
 - Seizure Disorder
 - Diabetes
 - Concussion
 - Asthma Requires inhaler
 - Pneumonia
 - Orthodontic Appliance
 - Headaches
 - Nose Bleeds
 - ADD/ADHD
 - Chicken Pox

- Allergies** (please check all that apply)
- Penicillin
 - Sulfa
 - Aspirin
 - Insect Bites/Stings
 - Other Drugs _____
 - Other Food _____
 - Ragweed
 - Hay Fever
 - Wheat
 - Peanuts
 - Dairy

Insurance Information

Medical Insurance Company _____

Insured Person _____ Policy Number _____

I have read and completed this Medical Information Form and attest that to the best of my knowledge it is accurate and complete. In the event of an emergency, I authorize the Camp Herrlich staff to take my child to any hospital facility for treatment deemed necessary. Furthermore, I hereby give permission to such hospital or outside doctor to authorize x-rays and emergency treatment if deemed necessary. I understand that all medical bills for services rendered are my responsibility.

Parent/Guardian Name (please print) _____

Signature of Parent or Guardian _____ Date _____

DAY CAMP MEDICAL INFORMATION FORM

This side must be completed and signed by a licensed physician.

Last Name _____ First Name _____ Weight _____

IMMUNIZATION HISTORY

New York State law requires that **current year** immunization information be provided prior to a camper's admission to camp.

Vaccine	Month/Year	Month/Year	Month/Year	Month/Year
DPT or DT				
Polio				
Measles				
Mumps				
Rubella				
HIB				
Varicella (Chicken Pox)				
HEP B				

Significant Medical History _____

Special Dietary Restrictions: _____

Activity Restrictions (if any) while at Camp Herrlich Day Camp: _____

CURRENT MEDICATIONS (All medications taken at camp must be in original containers with Pharmacy label attached)

Prescription Medications (Please complete with patient's current regimen for both scheduled and prn medications.)

Drug	Route	Dosage	Schedule and Indications	Comments

Standard Over the Counter/PRN Medications (The following are available in our infirmary and will be administered at the discretion of our camp nurse, if approval is indicated by the camper's healthcare provider.)

Camper's Health Care Provider Name: _____ Phone # _____

Address: _____ License # _____

Signature: _____ Date: _____

Drug Name	Route (please circle preferred formulation(s))	Dosage	Schedule and Indications	Camper Health Care Provider Order	Comments
Tylenol	PO (chewable tabs, elixir or tabs)	Per label instructions by age/weight	Q 4 hr prn for pain or fever > _____ F°	Yes No	
Ibuprofen	PO (chewable tabs, suspension, or tabs)	Per label Instructions by age/weight	Q 6 hr prn for pain or fever > _____ F°	Yes No	
Robitussin DM	PO (syrup)	Per label instructions by age/weight	Q 4 hr prn for cough	Yes No	
Pepto-Bismol	PO (liquid, or chewable tabs)	Per label instructions by age/weight	BID-TID prn for stomach upset	Yes No	
Kaopectate	PO (liquid)	Per label instructions by age/weight	Q 30 min to 1 hr prn for diarrhea (no>8 doses/24 hr)	Yes No	
Benadryl	PO (elixir, chewable tabs or pills)	Per label instructions by age/weight	Q 6 hr prn for allergic reaction (hives, insect bite)	Yes No	
Sudafed	PO (elixir or tabs)	Per label instructions by age/weight	Q 6-8 hrs prn for nasal congestion/drainage	Yes No	