

2018 CAMP WARWICK HEALTH RECORD

THE HEALTH RECORD MUST BE COMPLETED IN FULL AND INCLUDED WITH THE REGISTRATION FORM AND THE SIGNED WAIVER FORM BEFORE REGISTRATION WILL BE ACCEPTED.

Camper Last Name _____ Camper First Name _____ Initial _____

Family Physician _____ Physician's Telephone _____

Health Insurance Co. _____ Type of Policy _____ Policy # _____

Policy Holder Name and Address _____

Policy Holder's Date of Birth ___/___/___ Name of Employer Associated with Policy _____

Attach a photocopy of the insurance card (front and back). Employer Phone # _____

Prescription drug policy? Yes No If yes, attach a photocopy of the prescription card (front and back).

PLEASE NOTE: The Warwick Conference Center / Camp Warwick is not responsible for the cost of prescriptions, doctor visits, or emergency room visits during your camp stay.

*** FILL IN ALL INFORMATION ***

MEDICAL INFORMATION

Is your child in general good health and able to participate in all normal camp activities? Yes No

Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Throat problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Respiratory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	As infant	<input type="checkbox"/> Yes <input type="checkbox"/> No	Motion Sickness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Special Diet	<input type="checkbox"/> Yes <input type="checkbox"/> No	Current problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dizzy Spells	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetic	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chest Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures/Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Digestive Issues	<input type="checkbox"/> Yes <input type="checkbox"/> No	Irregular Heartbeat	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent nausea	<input type="checkbox"/> Yes <input type="checkbox"/> No
ADD	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low/high blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice/Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
ADHD	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ear infections	<input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty urinating	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hyperactivity	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hearing problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney infection	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emotional Issues	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vision problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hernia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Behavioral Issues	<input type="checkbox"/> Yes <input type="checkbox"/> No	Severe menstrual cramps	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chronic back pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Homesickness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Special Needs	<input type="checkbox"/> Yes <input type="checkbox"/> No	Neck Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No

Auto-Immune Conditions Yes No

FOR GIRLS: Been told about menstruation? Yes No Has menstruated? Yes No

Please give specific information and current status regarding any items marked "yes" above.

MEDICAL HISTORY - PLEASE LIST DETAILS & DATES BELOW. USE ADDITIONAL SEPARATE PAGE IF NEEDED.

Have you ever been hospitalized? Yes No If yes, reason and date: _____

Chronic recurring illness _____ Any broken bones _____

Severe head, neck or back injury _____ Date: _____

Contagious diseases _____ Date: _____

Serious operations (list date/type) _____ Date: _____

Recent illness/injury _____ Date: _____

Please submit statement of how your child has been medically treated and with what medication.

CAMPER NAME: _____

FOOD ALLERGIES

List food(s) your child is allergic to: _____

What type of reaction does your child experience when ingesting these foods?

Hives Yes No Anaphylactic Shock Yes No GI Disturbance Yes No

What treatment is given?

None Yes No Benadryl Yes No Epi-pen* Yes No

Is your child able to self-administer epi-pen? Yes No Other: _____

**Requires a doctor's order. Complete Medical Authorization Form sent in confirmation packet.*

Camp Warwick makes every attempt to accommodate food allergies and sensitivities. However, in cases of potential life-threatening allergies families are encouraged to send their own food and snacks. We encourage you to call two weeks prior to your child attending camp to discuss specific arrangements at 845-986-1164. Ask for Arlene Tenckinck.

SKIN ALLERGIES

Yes No If "yes", please list: _____

MEDICATION ALLERGIES

List any prescription or over-the-counter medications that your child is allergic to: _____

OTHER ALLERGIES

Bee Sting Yes No Poison Ivy/Oak/Sumac Yes No
Hay Fever Yes No Suntan Lotion Yes No

Reaction: _____

Treatment: _____

IMMUNIZATIONS

New York State requires your child to have the following immunizations. **PLEASE ATTACH AN OFFICIAL IMMUNIZATION RECORD FROM THE CHILD'S DOCTOR'S OFFICE.**

DPT Varicella M.M.R. Hepatitis B Series Oral Polio Vaccine HIB

All immunizations are required unless a) it is medically contraindicated (doctor's signature required) or b) choose not to for religious reasons (documentation by religious leader necessary).

MEDICATIONS / CAMP WARWICK CAMPERS - USE ADDITIONAL SEPARATE PAGE IF NEEDED

List any medication (prescription and over-the-counter) that your child is currently taking: _____

I give permission to the Camp Warwick Health Director to supervise the self-medication of the following: *(Check off)*

- Antacids / Tums Cold medications Tylenol Ibuprofen (Advil or Motrin)
- Cough syrup/drops External ointments Suntan lotion Benadryl

Other over-the-counter medications (list): _____

The Camp Warwick Health Director will supervise the self-medication of prescription and over-the-counter medicines by campers at on-site camps and oversee the First Aid personnel of off-site camps in the distribution of medicine. All medications (prescription and over-the-counter) must be given to the Health Director at the time the camper checks in. The Health Director stocks most common medications such as Tylenol and cold remedies, so it is not necessary to bring them to camp. All prescription medications must be in the original container, labeled with the camper's name, and written instructions signed by your physician must accompany the medication. All over-the-counter medications must be in the original container and labeled with the camper's name. A **USE OF MEDICATION POLICY FORM** is enclosed.

2018 CAMP WARWICK WAIVER* FORM

**THIS FORM MUST BE COMPLETED BY PARENT/ GUARDIAN
BEFORE REGISTRATION WILL BE ACCEPTED.**

Please use one form per child. Copies may be made of this form.

CAMPER INFORMATION

Camper Last Name _____ Camper First Name _____ Initial _____

Parent/Guardian Full Name _____

Best Telephone Number to reach Parent/Guardian: _____ Home Cell Work

***NO NOTARY SIGNATURE IS REQUIRED.**

CAMP WARWICK REGISTRATION & HEALTH RECORD CONSENT WAIVER

In signing this waiver, I certify that the information on the Camp Warwick Registration Form and Camp Warwick Health Record is correct. In case of a medical emergency, I authorize the release of medical records and understand that every effort will be made to contact the parent/guardian. In the event that the parent/guardian cannot be reached, permission is hereby given to the physician selected by The Warwick Conference Center to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child/ward, as named herein. I understand that I am responsible for the cost of prescriptions, doctor visits and/or emergency room visits during my child/ward's stay at Camp Warwick.

I authorize the Camp Warwick Health Director to supervise the self-medication of prescription and over-the-counter medicines by my child/ward at on-site camps and supervise the First Aid Personnel of off-site camps in the distribution of medicines.

I give permission for my child/ward to be transported in the Warwick Conference Center vehicles to and from public transportation. I give permission for my child/ward to be transported in the Warwick Conference Center vehicles as necessary for approved off-site camp activities.

I authorize the use of photographs and videos of my child/ward in camp publicity.

PARENT/GUARDIAN SIGNATURE

DATE