Salesian Camp Echo Bay
Medical and Emergency Form

This information on this form is gathered to assist us in identifying appropriate care for the camper.
The parent or guardian of the camper can fill out this form **EXCEPT FOR** the **"Health History and Recommendations of a Licensed Medical Person"**.
If there is an order of protection or visitation order for the camper please submit a copy with this form.
This form MUST be on file in the camp Health Office **BEFORE** your child begins camp in order for your child to participate.

Medical and Emergency Form

Camper's Name: _____
Date of Birth: _____ Age of Camper: _____
Gender of Camper: (m) (f)
Home Address: _____
_____
Home Phone Number: (____)_____
Name of Custodial Parent or Guardian: _____
Mother or Guardians **Work** Number: (____)_____
Cell Phone Number: (____)_____
Father or Guardian Work Number: (____)_____
Cell Phone Number: (____)_____

Emergency Phone Numbers
1) Name: _____
Phone Number: (___)_____
Relationship to Camper: _____

2) Name: _____
Phone Number: _____
Relationship to Camper: _____

Doctor's Name: _____
Doctor's Phone Number: _____

Hospital Release and Parent Authorization

I give permission, in case of injury to take my child _____, to the hospital for treatment, to include evaluation of injuries, x-rays, and emergency care.

Parent's Signature: _____ Date: ____/____/_____
Hospitalization Insurance Company: _____
Identification Number: _____

The New York State Health Department must have this completed and returned to

the Health Office **BEFORE** the child begins camp. Thank you

Medication Being Taken

List all medication, prescription and non-prescription drugs routinely taken:

_____
_____
_____
_____
_____
_____

If the camper takes no medication on a routine basis, check here: ( )

Authorization for administration of medication at camp; prescription and non-prescription:

I request that my child, _____ receive the medication as prescribed in the following section by our Licensed Medical Professional. The medication is to be furnished by me in a properly labeled original container with child's name.

I understand the Camp Nurse or other assigned person will administer the medication.

Parent Signature: _____
Date: _____/_____/_____

THE FOLLOWING IS COMPLETED BY A LICENSED MEDICAL PROFESSIONAL SIGNATURE AND STAMP REQUIRED.

Health History

1) List all known allergies or medical problems.
   Describe reaction and management of the reaction or care for medical problem.
   _____
   _____
   _____
   _____

2) List all Food Allergies:
   _____
   _____
   _____
   _____

3) All other allergies: include stings, hay fever, asthma, reactive airway, disease, etc:
   _____
   _____
   _____
   _____

I request that my patient, as listed below, receive the following medication:
Name of Camper: _____ Date of Birth: _____/_____/_____
Diagnosis:
_____
_____
Name of Medication:
_____
_____
Prescribed dosage, frequently and route of administration:
_____
_____
_____
Time to be taken at camp: _____ (am) (pm)
Duration of treatment:
_____
_____
Possible side effects and adverse reaction (if any):
_____

_____
Other recommendations:
_____
_____
Any restrictions to activity at camp:
_____
_____
_____

IMMUNIZATIONS

Give all dates; include month, date, year, series complete, fully immunized, up to date, not accepted by the Health Department.

DPT/TD: ___/___/____ ___/____/____ ____/____/____
____/____/____
Pollo: ___/___/____ ___/____/____ ____/____/____
____/____/____
MMR #1 ____/____/____ MMR #2 ____/____/____
OR:
Measles: ____/____/____ Mumps: ____/____/____
Haemophilas Influenza (HIB): ____/____/____ ____/____/____
____/____/____
Hepatitis B: ____/____/____ ____/____/____ ____/____/____
Varicella: ____/____/____
TB Mantoux date of last test: ____/____/____
A) Results ( ) Positive ( ) Negative
B) Chest x-ray results if test positive:
_____
C) Medication:
_____
_____

Use this space to provide any additional information about the participant's behavior, physical, emotional or mental health about which the camp should be aware (ADD, ADHD, Diabetic, etc.)

_____
_____
_____
_____

Signature of Licensed Medical Professional:
_____
Professional's Name and Title (Please Print):
_____
Date: ____/____/____
Address: _____
_____
Phone: (____)_____

(Stamp to be used along with signature and date)