COOPERSTOWN DREAMS PARK

Camper Information: (*to be filled out by parent*)

2018

1234567890

Week attending (from/to)

Team Name: Team Number:

Last Name: First Name: Gender: DOB:

Address:

Parent/Guardian: Phone# Home Work Cell

Address:

If parent / guardian is coming to Cooperstown, address where they are staying (including phone #)

Health History

Yes / No

- ☐ ☐ Allergies (please list)
- ☐ ☐ Asthma ☐ Mild ☐ Moderate ☐ Severe ☐ Exercise Induced
- ☐ ☐ Diabeties
- ☐ ☐ Seizure Disorder
- ☐ ☐ Heart Disease (please explain)
- ☐ ☐ Other (please explain)

Immunization History: (Most Recent Date) A photocopy of immunization history is acceptable

DPT	Polio	MMR	Haemophilus Influenza Type B (HIB)	Hepatitis B Series Completed	Chicken Pox / Varicella (or disease date)	Meningitis

If your child is covered by health insurance please attach a photocopy of your camper's insurance card

- IMPORTANT - THIS CONSENT MUST BE COMPLETED FOR ATTENDANCE -

This health history is correct to the best of my knowledge, and the person herein described has permission to engage in all camp activities except as specifically noted. In the event of serious illness or injury, I hereby give Catskill Camp Services Inc. permission to provide emergency treatment and referral to a hospital in the event I can not be reached. I give permission to the physician selected by the camp Health Director to hospitalize, secure proper treatment for, and to provide anesthesia, pain control, and/or other invasive treatments in the event of severe illness or injury to my child as named above. I also give permission for my child's personal, protected medical information provided on this form, and any personal protected health information collected by personnel of Catskill Camp Services Inc. to be released to any hospital and/or clinic providing treatment, Cooperstown Dreams Park management, and any insurance company representing Cooperstown Dreams Park.

This form may be photocopied for use out of camp.

Required - PARENTAL AUTHORIZATION AND CONSENT - Required

Signature: **Date:**

I, (*the above indicated*) hereby authorize and entrust the below list of coaches and other persons to act in my place, to exercise full parental authority (including medical care authorization) and control over my child while at Cooperstown Dreams Park.

1. 5.
2. 6.
3. 7.
4. 8.

COOPERSTOWN DREAMS PARK

Camper Examination and Medications

This form is to be completed by a Physician, Physician Assistant, or Nurse Practitioner

Camper Exam ***Must Be*** within 12 months from the start of camp

Last Name: _____ First Name: _____

Team Name: _____ Week attending (from/to) _____ _____

Medications Listed Here: ---------->

New York State Department of Health requires that camps have an individualized set of standing orders for each camper attending. This list is for standard "Over the Counter" medications that campers may require while at camp. The medications will only be administered at the discretion of a Registered Professional Nurse. **A licensed health care provider needs to initial in the YES box if they wish the child to be eligible to receive the medication indicated.**

Per Label Instructions by Age/Weight as needed

Yes	No		Yes	No	
☐	☐	Acetaminophen (Tylenol)	☐	☐	Antibiotic Cream
☐	☐	Ibuprofen (Advil)	☐	☐	Calamine Lotion
☐	☐	Diphenhydramine (Benadryl)	☐	☐	Antacids (Tums)
☐	☐	Mylanta	☐	☐	Hydrocortizone 1% Cream
☐	☐	Phenylephrine (Sudafed)	☐	☐	_____
☐	☐	Dextromethorphan (cough syrup)	☐	☐	_____

All medications sent to camp must be in their original containers, including inhalers, which must come in their prescription labeled box
No pill boxes, or unlabeled containers will be accepted

Below, please ONLY list Daily, Prescribed, and PRN medications the child will need

WHILE AT CAMP

Drug Name	Dosage	Route	Schedule / Indication	Comments

The camper is under the care of a physician for the following conditions:

Physician ordered treatments to be continued at camp:

Health Care Provider Information:

☐ **In my opinion, this camper is able to participate in an active camp program**

Name _____ Phone _____

Address _____ License # _____

Provider Signature and Practice Stamp _____ ***Exam Date:*** _____

Camper exam ***Must Be*** within 12 months from the start of camp