CAMP GUGGENHEIM SUMMER CAMP

Please send the completed form to:
Diocese of Ogdensburg – Office of Youth Ministry
PO Box 369 – Ogdensburg, NY 13669
EMAIL SCANNED COPIES TO: LShoen@rcdony.org **OR FAX TO: 1-866-314-7296**
Questions/Concerns – Call 315-393-2920 ext. 1413

PARENT/GUARDIAN SECTION

Name of Camper:_____ **DOB:**_____ **Camp Start Date**: _____

Health Ins? __Y __N If 'Y' – Carrier Name_____ **Mem#** _____

Parent Name: _____ **Parent Phone:** _____

Emergency Contact Name:_____ **Phone:** _____

PHYSICIAN SECTION

Physician Name: _____ **License #** _____**Phone:** _____

Address: _____

Patient Information from Last Exam within 12 Months of Camp Start Date Above

Last Exam Date: _____ **Lungs normal?** _____ **Heart normal?** _____

Blood Pressure: _____ **Height:** _____ **Weight:** _____ **Muscular/Skeletal Normal?**_____

Are there any summer camp activity restriction orders? _____ YES (explain) ____ NO

*******(Please attach a copy of the IMMUNIZATION RECORD with this report)*******
Are immunizations up-to-date per NYS regs for camps/schools? ____ Yes ____ No
https://www.health.ny.gov/prevention/immunization/schools/school_vaccines

Prescription Medication

All medication is given by camp RN. Meds must be in original containers and correctly labeled.

Med Name	Route	Dosage	Routine/Schedule	Comments

(If additional space is needed, please attach a separate sheet)

Over the Counter Medication/PRN Permissions

Provider permission required for OTC/PRN meds.

Dosing is **per label instructions by weight**, unless otherwise noted by the provider below.

Med Name ***Circle Preferred Rt***	Permission Yes	 No	Schedule & Indications	Comments and Special Orders (Preferred Route, Dosage, etc)
Acetaminophen PO Tabs	◯	◯	Q 4 PRN for Pain or Fever >_____ F	
Ibuprofen PO Tabs	◯	◯	Q 6 PRN for Pain or Fever >_____ F	
Benadryl PO - Elixir / Chew Tabs / Pills	◯	◯	Q 6 PRN for Allergic Reaction	
Midol PO Tabs	◯	◯		
Tums PO Chew Tabs	◯	◯	Chew 1 or 2 tablets PRN	
Throat Lozenges PO Loz	◯	◯	Q 4-6 PRN for throat soreness	
Robitussin PO Elixir	◯	◯	Q 4-6 PRN for cough w/ or w/o fever or wheezing	
Sudafed PO Pills	◯	◯	Q 4-6 PRN for congestion	
Bacitracin Topical	◯	◯	Apply small amount to cut, burn or scrape 1-3 times/day	
Mylanta PO Elixir	◯	◯	Q 4-6 PRN for epigastric discomfort	
Imodium PO Elixir / Pills	◯	◯	As labeled PRN Diarrhea	

Please include reaction type and severity below:

Food Allergies: _____

Medicinal Allergies: _____

Other Allergies:_____

Allergy EAP: _____

Chronic Conditions: (Diabetes, Seizures, Asthma, etc) _____

Chronic Condition EAP: _____

(If additional space needed, please attach as separate sheet)

Does the camper have an EpiPen, Inhaler, or other medically necessary item? ____ Yes ____ No
If YES, are they able to carry and self-administer? ____ Yes ____ No

Explain/Orders: _____

_____

_____

History of Hospitalization? (explain) _____

History of surgery? (explain) _____

History of sleepwalking or other parasomnias? (explain) _____

_____

Additional Comments Regarding Any Conditions or Restrictions from Camp Activities, or Special Needs. Will the camper need/bring other OTC/PRN beyond the list above (Glucose pills, Hydrocortisone Cream, etc) If so, please provide orders?

Additional Orders:

<u>Provider Signature</u>

I affirm that the above medical information is accurate and that the camper has been examined within the past 12 months and is medically fit to participate in camp activities, except as limited by the restrictions or medical orders noted.

_____ _____ _____

Name: Printed **Signed Name** **Date**

Physician Stamp Below