CAMP NAGEELA 2010
CHECK LIST

Please use the check list below to make sure that all of you paperwork is filled out correctly and/or completely. Paperwork that is not filled out correctly and/or completely causes delays in your receiving admission cards and final information about camp.

MEDICAL FORM: ☐

1. PAGE 1: Please make sure that the insurance cards are attached securely. Please make sure that the appropriate boxes are checked off.
2. PAGE 2: Sign the consent form in **both** places (in the box and on the bottom of the page).
3. PAGE 3: Immunizations are filled out.
4. PAGE 3: Individual orders are filled out
5. PAGE 4: Doctor's name, phone number and signature are filled out.

TRANSPORTATION FORM: ☐

This form must be sent back to the camp office before May 15. 2010. Any form submitted after that date is not guaranteed transportation.

CANTEEN FORM: ☐

We strongly suggest that you do not give your child any cash to keep in the bunk house. Cash that is kept in the bunkhouse may get lost and/or stolen. We can only vouch for money that is submitted to the canteen. Children can purchase snacks daily and the money is deducted from what they have in their canteen account. Before each trip every child is permitted to take money out of their canteen account to spend as they wish.

CAMP APPAREL FORM: ☐

We find that those who do not purchase camp t-shirts, polo shirts, sweatshirts and baseball caps before camp begins take money out of their canteen fund to buy them. If you order it before camp begins then you receive it right away and do not have to wait to see if there are extra that you may purchase.

NO FAXES

Please return this form to the Camp Office:
110 Rockaway Turnpike Lawrence, NY 11559

ORIGINAL FORMS ONLY

Confidential Medical and Consent Form

CAMPER'S NAME: ____

HOME ADDRESS: ____

CITY: ____________________________ STATE: ____________ZIPCODE: __________

DATE OF BIRTH: ____________ PRESENT AGE: _______SOCIAL SECURITY NUMBER: ___________________

HOME PHONE NUMBER: _______________________ SUMMER PHONE NUMBER: __________________________

FATHER'S BUSINESS #: ________________________ MOTHER'S BUSINESS #: _____________________________

IN CASE OF EMERGENCY CALL: NAME: ______________________ PHONE NUMBER: _____________________

FATHER'S CELL PHONE #: ___________________________ MOTHER'S CELL PHONE #: _____________________

If child has a chronic or acute medical condition, it is imperative that the camp be notified. To speak to the camp nurse regarding confidential medical information about your child, please call her by June 15th at the number provided in the Directory of Information. All information will be held confidential.

MEDICAL AND PRESCRIPTION DRUG INSURANCE INFORMATION

Please make copies of your medical insurance card and paste it in the left box below. If you have separate prescription drug coverage, make a copy of that card and paste it in the right box below. **If no cards are attached, you will be billed at regular drug store rates for all drugs and you will be responsible for any additional medical costs.**

Drugs under $10 will be dispensed from our stock. It will not be processed under your plan and will be billed to you directly.

PASTE A COPY OF THE BACK OF YOUR MEDICAL INSURANCE CARD HERE	PASTE A COPY OF THE FRONT OF YOUR MEDICAL INSURANCE CARD HERE Please remember to complete the Insurance Information section on page 2 ❑ **I do not have Medical Insurance**	PASTE A COPY OF THE FRONT OF YOUR PRESCRIPTION DRUG CARD HERE ❑ My medical & drug coverage are the same. A copy of my card is already attached. ❑ I do not have drug coverage.

CAMP NAGEELA
Fallsburg, NY 12733

TO BE COMPLETED BY PARENTS

INSURANCE INFORMATION:
Company Name: __________________ Policy in the Name of: _____________________ Relationship: ________
Group Name & Number: ________________________ ID Number: ______________________________________
Other/Secondary Insurance Carrier and ID Information **if different from above**: ______________________________
____

Please detail any special circumstances or conditions that our medical or counseling staff should be aware of that will assist us in the care of your child (e.g. frequent colds, headaches, stomach aches, diarrhea/constipation, vomiting, bed-wetting, sensitivity to insect bites, homesickness, nightmares, anxiety reactions, etc.) and what you recommend as treatment. **Also please list medications camper will be bringing to camp.**
____
____

IMPORTANT: The camp office must be notified if your child is exposed to any communicable diseases during the three weeks prior to attending camp.

DEPARTMENT OF HEALTH REGULATIONS REQUIRES THE FOLLOWING AUTHORIZATIONS IF YOUR CHILD ATTENDS SLEEP AWAY CAMP

PARENTS' AUTHORIZATION TO TREAT & MENINGITIS VACCINATION RESPONSE
SIGNATURE REQUIRED TO ATTEND CAMP

1. This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted by me and the examining physican.

2. I hereby give permission to the physician selected by the camp director to order x-rays, routine tests and treatment for the health of my child, and in the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for my child as named above.

3. I have read the camp letter describing Meningitis, its transmission, the benefits, risks and effectiveness of immunization, availability and cost. (Please **CHECK ONE BOX AND SIGN BELOW**)

   ❑ My child has had the meningococcal meningitis immunization (Menomune™) within the past 10 years.
   Date Received: _______________
   ❑ I have read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that my child will **not** obtain immunization against meningococcal meningitis disease.
   Parent's signature: ____________________________ Witness: ________________________ Date: __________

AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR TEMPORARILY SEPARATED FROM HIS/HER PARENTS

I/We the undersigned, custodial parent(s)/guardian(s) of ______________________ a minor, do hereby authorize Camp Nageela, and/or Rabbi David Shenker, Director as our agent(s) to act in my/our name, place and stead in any way in which I/we could do, if I/we were personally present, with respect to said minor, including without limitation, giving consent to any diagnostic procedure or medical care which is deemed advisable by, and is to be rendered under the general or special supervision of, any licensed physician or surgeon on the staff of or engaged by Catskill Regional Medical Center or any other medical facility whether such diagnosis or treatment is rendered at the office of said physician or at Catskill Regional Medical Center or any other medical facility.

It is understood that this authorization is given in advance of any specific need for treatment but is given to provide authority on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the physician in the exercise of his best judgment may deem advisable.

The authorization shall remain effective until August 29, 2010 unless sooner revoked in writing delivered to said agent(s).

Parent(s) Signature ________________________ Witness ______________________________
Date ___________________________________ Date___________________
Phone Number of Parents ________________________ Additional Phone Numbers:_____________
Permanent Address: ____
Temporary Address: ____

CAMP NAGEELA
Fallsburg, NY 12733

TO BE COMPLETED BY EXAMINING PHYSICIAN

CAMPER'S NAME: ____

HOME ADDRESS: ______________________ CITY: ____________ STATE: _______ ZIP: __________

WEIGHT:______________________ HEIGHT: ______________________

Immunization History:

Please record month and year of basic immunizations and most recent booster. Please do not call our office for this information. We do not have it on file from previous years.

Immunization	Date Basic Series Completed	Most Recent Booster
DPT or DT		
POLIO		
MMR		
PPD/MANTOUX		
HEPATITIS A		
HEPATITIS B		
VARICELLA		

ALLERGIES	*YES*	NO	COMMENTS
PENICILLIN			
SULFA			
CEPHALOSPORINS			
OTHER MEDICATION			
FOOD ALLERGIES: LIST FOODS YOUR CHILD IS ALLERGIC TO:			
BEES/INSECT BITES			

Has your child ever had an anaphylactic reaction?

❑ **YES** ❑ **NO**

IF YES, YOU MUST SEND AN EPI-PEN ALONG WITH YOUR CHILD. (CHECK THAT IT HAS NOT EXPIRED OR YOU WILL BE BILLED FOR ONE ONCE IN CAMP.)

MEDICAL HISTORY:	DATE OF ILLNESS
Chicken Pox	
Measles	
German Measles	
Mumps	
Hepatitis	
Pneumonia	
❑ Positive PPD	DATE:
❑ CXRay	DATE:
TREATMENT PROTOCOL:	

Indicate if being treated for the following:

Diabetes: ____________________

Seizures: ____________________

Seasonal Allergies: ______________

Rheumatic Fever: ______________

Frequent: Ear Infections❑ Strep Throat❑

Asthma: ____________________

(If your child is being treated for asthma please send along the tubing for the nebulizer as well as all inhalers being used **AND make sure the nurse is notified before camp begins**.)

Individualized Orders

Standard Over-The-Counter/PRN Medications (available in the infirmary/first aid kit) to be administered at the discretion on an RN unless otherwise indicated by you.

DRUG or generic equivalent	ROUTE	DOSAGE	SCHEDULE	CONTRA-INDICATED Check only if med is not to be given	COMMENT
Tylenol	PO	Per label instruction by age/weight	q 3-4 hr prn for discomfort of elevated temp		
Ibuprofen	PO	Per label instruction by age/weight	q 6hr prn for discomfort or elevated temp		
Robitussin	PO	Per label instruction by age/weight	q 4-6 hr prn for cough		
PeptoBismol	PO	Per label instruction by age/weight	q 30 min to 1 hr prn for diarrhea (not>8doses/24hr)		
Mylanta	PO	Per label instruction by age/weight	TID-QID prn for gastric upset		
Dramamine	PO	Per label instruction by age/weight	½ hr before embarkation, then q 6-8hr prn for motion sickness		
Dimetapp	PO	Per label instruction by age/weight	q 6-8hr for nasal congestion/ drainage		
Benadryl	PO	Per label instruction by age/weight	q 6hr prn for allergic reaction		
Sudafed	PO	Per label instruction by age/weight	q 6-5hr for nasal congestion/ drainage		
Tums	PO	Per label instruction by age/weight	q 30 min prn for gastric upset/heartburn		
NaphconA	eye gtts	Per label instruction by age/weight	1-2 gtts affected Eye q 4-6 hr Itching/burning		
Milk of Magnesia	PO	Per label instruction by age/weight	BID-TID prn for Gastric upset/ Constipation		
Ear Drops	PO	Per label instruction by age/weight	Apply to affected area as indicated		
Cortisone Ointment	PO	Per label instruction by age/weight	Apply to affected area as indicated		
AntiFungal Ointment Spray	PO	Per label instruction by age/weight	Apply to affected area as indicated		

DEAR DOCTOR
PLEASE CONTINUE SIGNATURE REQUIRED ON NEXT PAGE

List Dates & Descriptions of Operations, Serious Injuries, Fractures: ____________________

____

Chronic or Recurrent Illness and Suggested Treatment: ____________________

____

SPECIAL RESTRICTIONS:

Diet: ____________________
Swimming: ____________________
Strenuous Activity: ____________________
Other: ____________________

____

____

To the best of my knowledge the information stated above is true and accurate and it is my opinion that the camper listed above is physically able to engage in all camp activities, except as noted above.

Signature Required

Physician's Signature: ____________________ Date: ____________________

Physician's Name: ____________________ Address: ____________________ Office/Emergency #: ____________

PARENTS PLEASE NOTE:

- If your child comes to camp with "over the counter" medications, try to make sure that they have enough for the entire trip or summer. Some of these "unusual" over-the-counter meds are not readily available at upstate pharmacies. These medications must be kept in the infirmary.

- If your child is coming to camp with year-round prescription medication, we must have a note from your doctor detailing the medication prescribed, the dosage, time and frequency it should be taken, as well as the reasons for taking the medication. No UNLABELED MEDICATION will be dispensed. Verbal information about medication is insufficient. All medication must be kept in the infirmary.

- At the suggestion of our doctors, allergy medication/shots should be started about a month prior to camp to facilitate relief during the summer. We will be glad to continue the treatments.

- To avoid any possible embarrassment and discomfort to your child, please be sure to check him/her thoroughly for the presence of lice prior to sending him/her to camp. It is in your child's best interest to address this problem, at home, even at the expense of missing the first few days of camp.