# CAMP NAGEELA
**Fallsburg, NY 12733**

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

NO FAXES

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

## 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 23, 2011 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 the more "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.

- For everyone's protection, all campers and staff members are required to have their hair checked for lice infestation immediately prior to camp. We have arranged to have a professional checker at the bus stop. Therefore it is imperative that you arrive by 9:15. **Note -** In order to avoid the discomfort of discovering nits on the day of departure, we suggest that you have your child checked by a knowledgeable nit checker before 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.