Camp Hollis Medical Form

Please return completed form to: Oswego City-County Youth Bureau, 70 Bunner St, Oswego NY 13126

Camper's Name _____ M _____ F _____ Home Phone # _____
DOB _____ Dates Attending Camp _____
Attended Camp Hollis last year? Yes _____ No _____

Section A: Health History → to be completed by parent/guardian

Please attach a copy of Immunization Record and latest physical to this form.
(You can obtain a copy from your doctor's office or school nurse.)
In the last few years has the child ever had: (Circle Yes or No)

Hay fever: Yes No	Frequent ear infection: Yes No	Severe reaction to poison ivy: Yes No
Asthma: Yes No	Convulsions/seizures: Yes No	Diabetes: Yes No
Bed Wetting: Yes No (If "Yes" are pullups used? Yes No)		Bleeding/Clotting Disorder: Yes No

Severe reaction to insect or bee stings: Yes No If "Yes", is medication provided? _____
Reaction: _____

Food Allergies: Yes No If "Yes", to what food(s)? _____
Reaction: _____

Please note any operations, special circumstances, restricted activities, emotional/behavioral problems, or recurring illness you feel we should be aware of (attach additional paper if needed):

_____

The Health History is correct to my knowledge. The person herein described has permission to engage in all prescribed camp activities except as noted.

_____ _____ _____
→ Parent/Guardian Signature Address Emer. Phone #

Release of Information

I authorize Oswego County/Camp Hollis to obtain information such as physical forms, immunization records and medication prescriptions for camp record requirement and retention. This information may be obtained by mail, phone and/or electronic transmission. Information about the camper's care, medical history and/or medication may be obtained from _____ and released to CAMP HOLLIS/Oswego County.
(Physician's Office and Phone Number)

→ Parent/Guardian Signature: _____ Date: _____

Section B: Prescribed Medications/Treatments

NOTE: This section must be completed and signed by a Doctor, Physician's Assistant or Nurse Practitioner.
PARENTS: WITHOUT THIS SIGNED DOCUMENT, THE HEALTH CENTER AT CAMP HOLLIS CANNOT SUPERVISE YOUR CHILD'S SELF-ADMINISTERING MEDICATIONS (AS APPROVED BY OSWEGO COUNTY HEALTH DEPT).

ORDERS FOR MEDICATIONS/TREATMENTS:
ALLERGIES: _____
MEDICATION CONDITIONS: _____

*Medication/Dose	Route	Time of Day	Frequency	Reason

* All medications must be in the original container, properly labeled.
Specific PRN Medications/Treatments: _____

_____ _____ _____
→ Physician/Nurse Practitioner Signature Date Physician's Phone Number

Section B: Prescribed Medications/Treatments (Additional Sheet)

*Medication/Dose	Route	Time of Day	Frequency	Reason

→ Physician/Nurse Practitioner Signature | Date | Physician's Phone Number

Section C: Over the Counter Medications/Treatments

NOTE: This section must be completed and signed by a Doctor, Physician's Assistant or Nurse Practitioner

PARENTS: Please note that without this document the Health Center at Camp Hollis cannot supervise your child's self-administering any over-the-counter medications and/or provide over-the-counter medications PRN (PRN = as needed).

INDIVIDUALIZED STANDING ORDERS FOR: _____ (Camper's name):

These medications are available in our Health Center, and are to be dispensed following the site's Medical Guidelines. They are approved by Oswego Hospital Emergency Room Physician. Generic forms of the drugs may be used.

1. Mark an "X" to the left of any medications you wish your child/patient to receive if needed.
2. Please provide signatures of both the camper's Parent/Guardian and Physician/Nurse Practitioner at the bottom of the page.
   Medications will not be given without written physician orders.
3. Over the counter medications provided by camper's family must be in the original container, properly labeled.

___ Acetaminophen:	Per label instructions by age/weight, every 4 hours as needed for headache, fever musculoskeletal complaints, menstrual cramps, minor pain
___ Antibiotic Ointment:	To prevent infection
___ Benadryl:	Per label instruction by age/weight, every 6 hours as needed for minor sting/topical reactions to insect bites, poison ivy, oak or sumac
___ Calamine Lotion:	For dry skin and relieving itch of poison ivy, oak or sumac
___ Cortisone Ointment:	For exposure to poison ivy, oak or sumac, to relieve itching
___ Chloraseptic:	One lozenge/spray every 2 hours as needed for sore throat
___ Eye Drops:	Two drops in each eye twice a day for irritated or watery eyes
___ Hydrogen Peroxide:	To be used as an antiseptic
___ Ibuprofen:	Per label instructions by age/weight, every 6 hours as needed for mild headache, musculoskeletal complaints, menstrual cramps
___ Swim-EAR	4-5 drops in affected ear 2 times a day for fluid in the ear

I give permission for the use of all the above medications in the treatment of my child marked with an "X". This permission will remain in effect until a replacement order is submitted in writing.

→ Physician/Nurse Practitioner Signature	Date	Physician's Phone Number

→ _____
Parent/Guardian Signature