NYID Camps

Health Paperwork Checklist

- **Personal Information and Medical Authorization (form 1)**
- **Health History (form 2)**
- **Proof of Physical (within 1 year from start date of camp)**
    - **Form 3 <u>OR</u>**
    - **Alternate physical form from Dr. office is acceptable**
- **Copy of Immunization Records**
- **Medication Form from Doctor (form 4)**
- **Photo Release (form 5)**

NYID Camps LLC

Personal Information and Authorization for Medical Treatment of Minors

Camper's Information

Last_____ First_____ Gender: m / f

Age_____ Date of Birth _____ Sport Camp_____

Address_____

City_____ State_____ Zip_____ Phone_____

Parent/ Guardian Information

Father/ Guardian_____ Mother/ Guardian_____

Address (if different)_____ Address (if different)_____

_____ _____

Cell Phone: _____ Cell Phone:_____

Work Phone: _____ Work Phone:_____

Emergency Contact (Other than Parent/ Guardian)

Name_____ Relationship:_____

Phone:_____ Address:_____

City:_____ State_____ Zip_____

I/We, being the parent(s) or legal guardian(s) of the above named minor, do hereby appoint the staff of NYID Camps to act in my/our behalf in authorizing emergency medical, dental, surgical care and/or hospitalization of the above named minor for the period of NYID Summer Camps. By signing below, I hereby allow for the staff of NYID Camps to make medical decisions for my/our minor child in our absence and, furthermore, attest that the information provided is correct to the best of my/our knowledge.

I am also giving written permission for my child to carry and use sunscreen to protect against overexposure from the sun, following the SED memorandum for public schools. In addition, this allows the camps medical staff to use sunscreen as needed to protect my/our child from over exposure as well, provided it is approved by the FDA for over-the-counter use.

Signature_____ Date:_____

Name: _____ Camp: _____ Date of Birth: _____

General Medical Information

Please indicate if you or a family member have or has had any of the following illnesses or disorders. Please check yes or no. If yes, indicate self or family.

	YES	NO	Self	Family	Date(s)
Mononucleosis					
Hepatitis					
Asthma					
Diabetes					
Epilepsy or Convulsive Disorder					
Anemia (include Sickle Cell)					
Heart Disorder					
Respiratory Disorder					
Kidney Disorder					
Gastrointestinal Disorder					
Eye, Ear, Nose Disorder					
Other Organ Disorder					
Absence of a Paired Organ					
Concussion How many? ____					
Frequent or Severe Headaches					
History of Fainting					
High Blood Pressure					
Thyroid Disease					
Heat Stroke or Illnesses					

Orthopedic Information

				Date	
Foot	☐ Yes	☐ No	☐ Surgery		
Ankle	☐ Yes	☐ No	☐ Surgery		
Low Leg	☐ Yes	☐ No	☐ Surgery		
Knee	☐ Yes	☐ No	☐ Surgery		
Thigh	☐ Yes	☐ No	☐ Surgery		
Hip	☐ Yes	☐ No	☐ Surgery		
Spine	☐ Yes	☐ No	☐ Surgery		
Chest	☐ Yes	☐ No	☐ Surgery		
Shoulder	☐ Yes	☐ No	☐ Surgery		
Upper Arm	☐ Yes	☐ No	☐ Surgery		
Elbow	☐ Yes	☐ No	☐ Surgery		
Forearm	☐ Yes	☐ No	☐ Surgery		
Wrist	☐ Yes	☐ No	☐ Surgery		
Hand	☐ Yes	☐ No	☐ Surgery		
Head	☐ Yes	☐ No	☐ Surgery		
Neck	☐ Yes	☐ No	☐ Surgery		
Other	☐ Yes	☐ No	☐ Surgery		

Explanations: _____

. Do you wear eyeglasses or contact lenses during participation? ☐ YES ☐ NO

! Do you wear any type of dental appliances? ☐ YES ☐ NO

; Do you have any known allergies? ☐ YES ☐ NO
If yes, please list: _____

; Do you currently take any medications? ☐ YES ☐ NO
If yes, please list: _____

; Do you have any other type of illness/condition/injury that we should be aware of? ☐ YES ☐ NO
If yes, please explain: _____

_____

declare the above information is accurate and current.

ignature: _____ Date: _____

Sport Camp _____

Name: Last_____ First _____ Date of Birth _____

Proof of a physical and immunizations is required for participation in summer sports camps at SUNY Cortland. If you have not already had a physical, please take this form to your doctor's appointment.

Date of exam: _____ Blood pressure:_____ Height:_____ Weight:_____ Vision: Right 20/____ Left 20/____
__ Corrected __ Uncorrected

	Normal	Abn.	Explanation
Head, Ears, Nose, Throat			
Respiratory			
Cardiovascular			
Gastrointestinal			
Hernia			
Eyes			
Genitourinary			
Musculoskeletal			
Metabolic/Endocrine			
Neuropsychiatric			
Skin			

Is this patient now under treatment for any medical or emotional condition? Yes ____ No ___
Are there any restrictions on physical activity related to classes or sports? Yes? ___ No ___
If yes please explain_____

Immunization Record – MUST BE SBMITTED ON ALL CAMPERS BORN ON OR AFTER JANUARY 1, 1957

Immunization	Date given Mo./Day/Year	Serology date	Immune Yes	Immune No	Physician diagnosed disease/date of onset
MMR combined (2 doses)	#1 #2	N/A	N/A	N/A	
Measles (2 doses live vaccine on or after first birthday and after 1967) and	#1 #2				
Mumps (1 dose of live vaccine on or first birthday) and					
Recommended					
Hepatitis A	#1 #2	Serology date and results _____			Physician diagnosed disease / Date and onset _____
Hepatitis B	#1 #2 #3	Serology date and results _____			N/A
Varicella (Chickenpox)	#1 #2	Serology date and results _____			Physician diagnosed disease / Date and onset _____
HPV vaccine	#1 #2 #3	N/A			N/A
Tetanus/Diphtheria/Pertussis (with in 10 years)	TD given ____/____/____ or Tdap given ____/____/____				
Meningococcal vaccine	Menactra given ____/____/____ or Menomune given ____/____/____				

This section or an additional official immunization record must be signed by a healthcare provider.

Examiner's signature_____ Date: _____
Print Name and title _____
Address_____Telephone _____

MEDICATION FORM

This form must be signed by the prescribing physician or be accompanied by the prescription/proof of prescription (label on prescription bottle).

ALL prescribed medications that are declared at check in must be handed in to Camp Health director to be administered during camp.

**The only exceptions declared by the NYS Department of Health are asthma inhalers or Epi-pens.

Camper Name:_____ Date of Birth:_____

Medication Dosage:_____

Route of administration:_____

Times to administer:_____

Special considerations:_____

Physicians Name and contact information:_____

_____

All medications must be in the original packaging with medication, dosage, and expiration date clearly visible on packaging.

*****This form must be completed for each and every medication that needs to be administered at camp.*****

Parent's Signature:_____ Date:_____

Physician's Signature:_____ Date:_____

If prescription script/proof of prescription is not provided

Photo Release Form

NYID Camps LLC requests permission to use your child's photograph in NYID promotional materials as needed. Please read and sign below authorizing this use if you are in agreement of the terms.

Date:_____

I hereby consent to and authorize the use and reproduction by NYID, or anyone authorized by NYID, of any and all photographs that have been taken of my child, without compensation to me.

All negatives and positives, together with the prints, are owned by NYID and I understand that NYID reserves the right to use these photographs in any of its publicity.

I have read and understood the terms of this release. Parents under the age of 18 must take responsibility for signing this document.

Child's Name (please print) _____

Parent's Name_____

Parent's Signature_____