Form 1

Please staple all pages together

1a

RESIDENTIAL CAMP
PRESCRIPTION AND OVER THE COUNTER MEDICATION FORM

THE FOLLOWING FORM MUST BE COMPLETED BY ALL PARENTS OF CHILDERN ATTENDING THIS CAMP AND SUBMITTED AT CHECK-IN

If your child will be taking medication while at camp, it is state law to secure your consent for medication distribution and for the use of medical devices. In addition to your consent, the prescribing physician must provide sign off on all medications, including over-the-counter medications, to be used at camp.

CAMPERS INFORMATION	
Child's Name	
Child's Age	
Host Camp Location	
Camp Dates	

Will your child require medication(s) while at camp? This includes EpiPens, Inhalers and Over-the-Counter medications. (Check appropriate box)

Yes		If "Yes", please complete the included Medication Form with your child's physician and submit it to the Health Director at camp check-in.
No		If "No" is answered, your child must not be in possession of **ANY** medication at camp. You only need to complete and sign page one of this form.

Will the camper be carrying FDA approved sunscreen? If so please select YES to provide parental/guardian permission to carry the sunscreen. If no is selected the camper will not be permitted to carry sunscreen in their bags. Campers must be able to apply
Yes ( ) No ( )

Campers are **NOT ALLOWED** to hold onto medication while at camp. **ALL** medications must be submitted with this accompanying document to the Health Director of the camp for proper storage and administration. If your child is found in possession of medication, either prescription or over-the-counter medication, parents will be called for immediate pick up from camp. At camp check-in, **ALL** prescription and over-the-counter medications along with this from must be submitted to the Health Director. Prescription medications must be in their **original containers** bearing the pharmacy label and have specific instructions for use (Child's name, dosage, # pills inside, prescribing practitioner, pharmacy name & address, filler's initials, serial #). Important: Due to Department of Health Regulations "as needed" medication must include a dosage and frequency and will only be given "as needed" with parental approval which will be obtained via a phone call. If the parent does not provide approval the camper will not be permitted to take the medication.

PARENT/GUARDIAN INFORMATION	
Parent/Guardian Name	
Parent/Guardian Signature	
Date	

Self-Administration: A self-administration process is used on NY residential camp programs. Self-administration of medications will **only** be allowed for those individuals determined to be "self-directed". Determination as to whether or not a camper should be considered for self-administration will be conducted by the Health Director or designee and will be based on the camper's ability to:

- Identify the correct medication (e.g., color, shapeIdentify the purpose of the medication (e.g., to improve attention),
- Determine that the correct dosage is being administered (e.g., one pill),
- Identify the time the medication is needed (e.g., lunch time, before/after lunch),
- Describe what will happen if medication is not taken (e.g., unable to pay attention), and

1b

RESIDENTIAL CAMP
PRESCRIPTION AND OVER THE COUNTER MEDICATION FORM

- Refuse to take medication if camper has any concerns about its appropriateness.

In the event that the Health Director determinies the child cannot self-administer, medication will not be provided for self-administration and the child's parents will be called for child pick up. In general campers will not be allowed to self-administer "as needed" (PRN) medications, except for emergency medications such as inhalers and epinephrine auto-injectors, or when directed by the camper's physician and/or parent.

Over-The-Counter Medication

CAMPER INFORMATION	
Child's Name	
Child's Age	
GROUP INFORMATION (TO BE COMPLETED BY CAMP DIRECTOR)	
Assigned Coach	
Group Color	
Camp Dates	

IMPORTANT NOTE: Over-The-Counter (OTC) medications must be in their **original containers** bearing the original label and have specific instructions for use (Child's name, dosage amount and frequency, prescribing practitioner).

Will your child require Over-The-Counter (OTC) medication at camp? (Check appropriate box)

Yes		If "Yes", please complete the below for all OTC medications your child will require while at camp.
No		If "No" is answered, your child must not be in possession of **ANY** OTC medication at camp.

IMPORTANT NOTE: If your child requires any OTC medication while at camp, it is **required by law** that a prescription be written and provided at camp check-in for each OTC medication.

OTC Medication Name	Yes	No	Internal or External	Refrigeration Required (Y/N)	Prescription Provided
Benadryl					
Advil					
Tylenol					
Excedrin					
Claritin					
Pepto-Bismol					
Dimetapp					
Cortaid					
Midol					

If your player's OTC medication is not included in the list above, please enter the name of the medication in the table below:

OTC Medication Name	Yes	No	Internal or External	Refrigeration Required (Y/N)	Prescription Provided

RESIDENTIAL CAMP
PRESCRIPTION AND OVER THE COUNTER MEDICATION FORM

EPIPENS

EpiPens must be submitted to the Health Director at camp check-in along with this accompanying document. Only if specifically authorized by the parent will the camper be allowed to hold the EpiPen, however, the Health Director must still be made aware of the presence of the EpiPen.(It is the camps preference for the Health Director to store all EpiPens).

CAMPER INFORMATION	
Child's Name	
Child's Age	
GROUP INFORMATION (TO BE COMPLETED BY CAMP DIRECTOR)	
Assigned Coach	
Group Color	

Will your child require an EpiPen at camp? (Check appropriate box)

Yes		If "Yes", please complete the section below.
No		If "No" is answered, your child must not be in possession of **ANY** EpiPens at camp.

If yes, what is the reason the camper requires an EpiPen? ____

Is the child prescribed by a doctor to self-administer the EpiPen? If "Yes", circle Y or N in response to whether a prescription was provided.

Yes		Prescription Provided	(Y / N)
No			

Prescribing Physician's Information

Physician Name	
Office Address	
Office Contact Number	
Physician's Signature	

Post Camp Action - To be completed by Camp Staff

EpiPen – Following camp the EpiPen must be returned to the parent or destroyed. (Check appropriate box)

Returned to Parent	
Destroyed	

1d

RESIDENTIAL CAMP
PRESCRIPTION AND OVER THE COUNTER MEDICATION FORM

Prescription Medication (#1)

CAMPER INFORMATION	
Child's Name	
Child's Age	
GROUP INFORMATION (TO BE COMPLETED BY CAMP DIRECTOR)	
Assigned Coach	
Group Color	

IMPORTANT NOTE: Prescription medications must be in their **original containers** bearing the pharmacy label and have specific instructions for use (Child's name, dosage, # pills inside, prescribing practitioner, pharmacy name & address, filler's initials, serial #).

Medication #1

Medication Name	
Expiration Date	
Condition for Use	
Amount/Dosage	
Time/Frequency	
Instructions for use? How is it administered?	
Internal or External medication?	
Does it require refrigeration?	
Side Effects, if any	

Prescribing Physician's Information

Physician's Name	
Office Address	
Office Contact Number	
Physician's Signature	

Medication #1 Self Administration Log (To be completed by Health Director at time of administration)

Date	Time	Dosage	Health Director's Signature	Parent Approval - PRN Meds

Post Camp Action - To be completed by Camp Staff

Medication #1 – Following camp the medication must be returned to the parent or destroyed. (Check appropriate box)

Returned to Parent	
Destroyed	

1e

RESIDENTIAL CAMP
PRESCRIPTION AND OVER THE COUNTER MEDICATION FORM

Prescription Medication (#2)

CAMPER INFORMATION	
Child's Name	
Child's Age	
GROUP INFORMATION (TO BE COMPLETED BY CAMP DIRECTOR)	
Assigned Coach	
Group Color	

IMPORTANT NOTE: Prescription medications must be in their **original containers** bearing the pharmacy label and have specific instructions for use (Child's name, dosage, # pills inside, prescribing practitioner, pharmacy name & address, filler's initials, serial #).

Medication #1

Medication Name	
Expiration Date	
Condition for Use	
Amount/Dosage	
Time/Frequency	
Instructions for use? How is it administered?	
Internal or External medication?	
Does it require refrigeration?	
Side Effects, if any	

Prescribing Physician's Information

Physician's Name	
Office Address	
Office Contact Number	
Physician's Signature	

Medication #1 Self Administration Log (To be completed by Health Director at time of administration)

Date	Time	Dosage	Health Director's Signature	Parent Approval - PRN Meds

Post Camp Action - To be completed by Camp Staff

Medication #1 – Following camp the medication must be returned to the parent or destroyed. (Check appropriate box)

Returned to Parent	
Destroyed	

Please make additional copies of this form if more than two medications are being submitted

Form 2

NCE Camper Immunization Record

Name of camper	
Age of camper	
Date completed	

State Health and Safety regulations require that your child is up to date with age appropriate vaccinations as listed below.

Campers who aren't vaccinated won't be permitted on camp unless there is a bona fide medical or religious exception.

For more information on state vaccination requirements visit:

NJ Vaccination Guide
NY Vaccination Guide

#	Immunization	Most Recent Dose – Month and Year
1	Diphtheria/Tetanus	
2	Haemophilus Influenza type B	
3	Hepatitis B	
4a	Measles, mumps, rubella (MMR)- Dosage 1	
4b	Measles, mumps, rubella (MMR)- Dosage 2	
5	Poliomyelitis	
6	Varicella (chicken pox)	
7	Has the camper recently been exposed to a contagious disease	Yes No

I certify that this information accurently reflects the immunization history of the camper name listed above

Parent/Guardian Name____________________ Signature_______________________ Date ________

****

IMMUNIZATION EXEMPTION REQUEST

☐ On religious, grounds, I request exemption for my child from all vaccinations and/or immunizations required for attendance at this camp

☐ On medical grounds, I request exemption for my child from all vaccinations and/or immunizations required for attendance at this camp

Parent/Guardian Name_____________________ Signature__________________________Date ________

Form 3

INITIAL HEALTH SCREENING AND EXIT FORM
RESIDENTIAL CAMPS

Dear Parent – This form should be completed ***prior*** to arrival and reviewed with the Health Director or designee at check-in.

Camper Name:		Screening Date:	
Camp Location:		Screened By: (Camp use only)	

CAMP INTAKE

Initial Health Form Reviewed: ☐ Immunization Form Reviewed ☐ Medication Form Reviewed: ☐

(1) Since online registration, has there been any changes to the information provided in the Health History Form? Are there any new health concerns or issues that we should be aware of?
( ) Yes ( ) No *Add comments below:*

(2) Does your child have any signs/symptoms of illness or injury upon check-in?
( ) Yes ( ) No *Add comments below:*

(3) Has the child had any exposure to communicable disease in the two weeks prior to the camp?
( ) Yes ( ) No *Add comments below:*

(4) If applicable, medication given to health-care staff?
( ) Yes ( ) No ( ) N/A
Comments:

****

EXIT NOTES – CAMP USE ONLY

(1) Camper left camp with no reported illness or injury symptoms.
( ) Yes ( ) No *If yes list issues*

(2) Were all incidents for this camper recorded on the medical log
( ) Yes ( ) No

(3) Has the parent/guardian been notified of injuries/incidents
( ) Yes ( ) No ( ) N/A

Exit Report Conducted By	
Date	

Form 4

MISSING PACKAGING FOR INHALER OR EPIPEN FORM

Dear Parent – A STATE Department of Health requirement on Residential Camps mandates that medication is in its original packaging or the medication **CANNOT** be accepted on camp

EXCLUSIONS

In the event that an INHALER or EPIPEN is missing its original container, parents are required to sign the form below and ensure that the following requirements are met:

(1) Instructions - Instructions for use are detailed on the medical devise.

(2) Doctors' Orders – The medical devise must be accompanied with a prescription.

(3) Expiration Date - The medical devise usage date should not have expired.

Camper Name:	
Camper DOB:	
Health Director Name:	
Medical Devise Type:	Inhaler EpiPen (Circle)
Instructions Listed on Devise:	Yes No (Circle) – If no cannot be excepted on camp
Prescription Provided:	Yes No (Circle) – If no cannot be excepted on camp
Parent Signature	
Camp Director Signature	

HEALTH HISTORY FORM – RESIDENTIAL CAMPS

Camper Name		Camper Age	
Family Doctor:		Doctor's Phone:	
Health Insurance Company:		Policy Number:	

SECTION 1: ALLERGIES:

List allergies below

Allergy Type:	Allergen:	Reaction:	Management:
Allergy Type:	Allergen:	Reaction:	Management:

SECTION 2: HEALTH QUESTIONS

Circle Yes or No, and explain additional information below:

Does the participant wear glasses or contact lenses?	Yes No	Ever had surgery?	Yes No	Have frequent headaches?	Yes No
Ever had a head injury?	Yes No	Has asthma?	Yes No	Ever had ear infections?	Yes No
Ever had back problems?	Yes No	Ever had emotional difficulties for which professional help was sought?	Yes No	Treated/diagnosed with attention deficit/attention hyperactivity disorder	Yes No
Had mononucleosis in the last 12 months?	Yes No	Have Diabetes	Yes No	Had seizures	Yes No

Does the camper have a server and chronic developmental disability? (mental retardation, cerebral palsy, epilepsy, autism or neurological impairment) Yes No. If yes please call the office prior to registration to discuss in more detail.

Additional Information/Is there any other medical issue that we should be aware of?

SECTION 3: MEDICAL – OVERNIGHT CAMPS

(a) MEDICAL QUESTIONS

Have problems with falling asleep?	Yes No	Have problems with sleep	Yes No	History of bedwetting	Yes

		walking			No

If applicable, has this camper started menstruation?

( ) Yes ( ) No

Does your child have a severe food allergy that requires an EpiPen or Benadryl?
( ) Yes ( ) No

Please explain below

Is the camper required to carry a prescribed Inhaler? If yes please ensure a doctor's prescription is shown at check-in

( ) Yes ( ) No

Will the camper be carrying tick or insect repellents? If so please select YES to provide parental/guardian permission to carry the repellents. If no is selected the camper will not be permitted to carry insect repellents in their bags.

( ) Yes ( ) No

Will the camper be carrying FDA approved sunscreen? If so please select YES to provide parental/guardian permission to carry the sunscreen. If no is selected the camper will not be permitted to carry sunscreen in their bags. Campers must be able to apply.

( ) Yes ( ) No

(b) DIET AND NUTRITION

This camper eats a regular diet ( ) Yes ( ) No

IMPORTANT NOTE: *For campers with special dietary needs, please call the office before registering to ensure that the host facility can accommodate the request.*

This camper eats a regular vegetarian diet ( ) Yes ( ) No

This camper is lactose intolerant ( ) Yes ( ) No

This camper is gluten intolerant ( ) Yes ( ) No

This camper has another dietary issue ( ) Yes ( ) No

(c) MEDICATION

If your child will be taking medication while at an overnight camp, the prescribing physician must provide sign off on all medications, including over-the-counter medications. Campers are **NOT ALLOWED** to hold onto medication while at camp. **ALL** medications must be submitted to the Health Director of the camp for proper storage and administration. If

your child is found in possession of medication, either prescription or over-the-counter medication, parents will be called for immediate pick up from camp. At camp check-in, **ALL** prescription and over-the-counter medications along with a completed MEDICATION form must be submitted to the Health Director. Prescription medications must be in their **original containers** bearing the pharmacy label and have specific instructions for use (Child's name, dosage, # pills inside, prescribing practitioner, pharmacy name & address, filler's initials, serial #).

Self-Administration: A self-administration process is used on NY overnight camp programs. Self-administration of medications will **only** be allowed for those individuals determined to be "self-directed". Determination as to whether or not a camper should be considered for self-administration will be conducted by the Health Director or designee and will be based on the camper's ability to correctly identify the medication, dosage and reason for need.

At the current time of registration, will the camper be required to take any prescription medication while attending camp?

( ) Yes ( ) No

At the current time of registration, will the camper be required to take any over the counter medication while attending camp?

( ) Yes ( ) No

I understand that all medication must be submitted to the health director at check-in with a completed medication form signed by a doctor.

( ) Yes ( ) No

The medication form, which needs to be signed by a doctor, will be sent to you following registration?

Please explain below

I understand that you will make every reasonable effort to reach me or the other listed emergency contacts for Participant provided by me in the event the Participant is injured while participating in the Camp or any other Event. However, in the event I or any other designated emergency contact cannot be reached, and in the event of any emergency in all cases, I hereby consent on behalf of all Participant Parties for the Participant to receive emergency medical treatment from a doctor or athletic trainer if needed. I further agree to be responsible financially for the cost of each assistance and/or treatment.

Name of Parent/Guardian (please print)			
Signature of Parent/Guardian		Date	