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UNIT BUNK________

CV 2017 HEALTH AND MEDICAL RECORD

CAMPER NAME____**BIRTHDATE**_________________**SEX**__________
HOME ADDRESS____**EMAIL**________________________________
CITY/STATE/ZIP_______________________ **PHONE**_______________**NICKNAME**______________**AGE**________

DOCTOR'S NAME_______________________________**CHART #**________**PHONE**_____________
HEALTH INSURANCE CO___________________**ID** _______________**SUFFIX/GROUP**___________

EMERGENCY CALL INFORMATION (parent/spouse called first unless otherwise requested)
MOTHER/GUARDIAN_______________________ WORK PHONE________________________________
EMAIL ____________________________________ CELL PHONE_________________________________
FATHER/GUARDIAN___________________________WORK PHONE________________________________
EMAIL _________________________________ CELL PHONE_____________________________

Additional emergency names and phone numbers (3 additional names **required** - neighbor, friends or relative)
1. NAME /RELATION___________________________HOME PHONE ___________________________
WORK PHONE______________________________CELL PHONE____________________________
2. NAME /RELATION___________________________HOME PHONE ___________________________
WORK PHONE______________________________CELL PHONE____________________________
3. NAME /RELATION___________________________HOME PHONE ___________________________
WORK PHONE______________________________CELL PHONE____________________________

EMERGENCY MEDICAL INFORMATION (to be completed by parent/guardian)
ALLERGY: (medicine, food, insect toxin, other)____
Medication used for allergies____
Allergy medication sent to camp: YES______ NO______

HISTORY OF: Asthma_________ Convulsions_________ Diabetes_________ High fevers_________
*Other medical conditions*____Explain_
Any condition requiring medication____
Medication for above____
Medications brought to camp: YES______ NO______
Does camper wear: glasses_________ contact lenses_________ braces_________ hearing aide_______

*If any medication is coming into camp, it must be accompanied by a note. The note should state the recipient's name, the medication name, amount to be given and time to be given. Prescription and "over the counter" medications **must** be in original, labeled bottles or containers. For prescription drugs, pharmacies will provide a duplicate empty bottle which is labeled and can be sent to camp with the medication. These rules apply to overnight and late stay medications as well as daily medications. **You must complete the Med. Consent (pg.3)**

AUTHORIZATION
In the event my child requires emergency medical care (as determined by the camp administration) while he/she is under camp jurisdiction, I authorize the doctor(s) and hospital to which my child is brought to perform all necessary emergency procedures and render treatment including the administration of anesthesia as necessary. I understand that attempts will be made to contact parents/guardians (and the emergency numbers listed on this form as necessary) before initiating this authorization.

Date___________Parent/Guardian____

Please return this completed form to: Camp Veritans, 225 Pompton Road, Haledon, New Jersey 07508 as quickly as possible.

rev. 1/2017

CV 2017 HEALTH AND MEDICAL RECORD (continued)

Camper Name____

Address____

Physician's Name________________**Phone Number**______________**Chart # (if applicable)**________

MEDICAL HISTORY (to be completed and signed by doctor)

IMMUNIZATIONS DATES

Measles__________________	DPT______________________________
Mumps __________________	Polio ______________________________
Rubella__________________	HiB ______________________________
Chicken Pox ______________	Hep B ______________________________
TB Mantoux_______________*	Tetanus Booster: last received__________________

CURRENT OR PAST HISTORY:

	NO	YES	YEAR	DETAILS
Injury				
Skin				
Glands				
Eyes				
Ears				
Nose				
Teeth				
dentures				
bridge				
Chest				
Bones				

	NO	YES	YEAR	DETAILS
Deformity				
Stomach				
Bowels				
Hernia				
Kidney				
Bladder				
wetting				
GYN				
Heart				
murmur				
other				

Behavior
Neurologic
Contagious
Other

Date of last physical exam (form should be based on a physical performed within the past 12 months)________________

Physician's signature____

***Please return this form to: Camp Veritans 225 Pompton Road, Haledon, New Jersey 07508** Rev:1/17

Medication Consent Form 2017

New Jersey State Law requires the use of a written consent form in order to dispense any medication in camp. This includes all over- the- counter medications (Tylenol, Advil/Motrin, decongestant, cough medicines, eye drops, etc.) as well as all prescription medications. This form **must be signed by both the parent and the doctor if you want to allow your child to be given ANY medication;** there can be **no exceptions** and **no** telephone (verbal) permission. Under no circumstances will medication be dispensed without proper documentation. This permission form will remain in effect for the camp season indicated (June-August). Any medication sent to camp must be in the original container appropriately labeled by the pharmacy or manufacturer. A new form must be filled out for each new camp year.

Lee Ann Beck, R.N.

Name of Camper_________________________________

Prescription Medications

Name of Medication_______________________________________ Dosage___________________
Reason for administration____
Time of administration____
Possible side effects____

Name of Medication______________________________________ Dosage____________________
Reason for administration____
Time of administration____
Possible side effects____

Over the Counter Medications

Acetaminophen/ Ibuprofen (circle appropriate medication) Yes__________ No____________
Dosage____
Reason for administration____

Pepto Bismol / Tums (circle appropriate medication) Yes______________ No________________
Dosage____
Reason for administration____

Other Medications____
Dosage_____________ Time of Administration (if applicable)__________________________
Reason for administration____
____

I authorize the camp nurse to administer the above medications as necessary. Parent will be called prior to administration of medications.

****Parent/ Guardian**______________________________________
****Physician**___________________________________ **MD STAMP:**

****MUST BE SIGNED BEFORE ADMINISTRATION****

Rev:1/17

Camper Medical Insurance Card Information 2017

A copy of your medical insurance card is required for your medical form to be complete.

Camper Name: ______________________

Attach Copy of front of Medical Insurance Card here

Attach Copy of Back of Medical Insurance Card here