



Place
Current
Photo
Here

UNIT BUNK _____

CV 2018 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 being 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. **In addition, 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.



CV 2018 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: date last received _____ Meningitis _____

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 _____



Medication Consent Form 2018

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****



Camper Medical Insurance Card Information 2018

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