

Camp Turner Health Forms v. 2023

PLEASE READ THESE INSTRUCTIONS

Physician's office

- Complete page 3 & 4, including medication authorization.
 - **Campers may not attend without these pages completed.**
- attach Immunization Records
- attach results of most recent physical
- Return pages to parents so they can send all the pages to camp as one packet.

Parents:

- Health Forms are due at camp at least one week before arrival.
- Parents are encouraged to let their doctor know what Over-the-counter medications their child is taking. We must have written orders for these as well as prescriptions.
- Parents complete pages 1 and 2.
- Including photo of camper's face on page 1. (Do not upload to your online account).
- Copy and retain all original pages.
- Mail copies of all pages (pages 1-4, plus immunization records and physical) to Camp Turner, PO Box 264, Salamanca, NY 14779 at least 10 days before scheduled arrival.
- **KEEP ALL PAGES TOGETHER IN ONE BUNDLE – DO NOT SEND DOCTORS PAGES AND PARENT PAGES SEPARATELY.**
- Bring originals to check in as backup.
- Do not upload Health Forms or Photos into your online account.

Campers who sign up for the optional trip (offered some sessions to ages 13 and up, see summer schedule) to the High Ropes Course, will need to download and complete a separate permission form. Check the website for details.

Camper's Name: _____ Date of Birth: _____ Session _____ Year _____

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Camper's Name: _____ Date of Birth: _____ Session _____ Year _____

Page 1

Camp Turner Health Forms v.2023
Camper Information (by parent)



Camper's Full Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Gender: _____

Height: _____ Weight: _____ Eye Color: _____ Hair Color: _____

Arrival Date _____ Age upon arrival _____

Parent / Guardian name	Home Phone	Work Phone	Cell Phone
_____	_____	_____	_____
Second Parent / Guardian name	Home Phone	Work Phone	Cell Phone
_____	_____	_____	_____
Emergency Contact (third option) name	Home Phone	Work Phone	Cell Phone
_____	_____	_____	_____
Agency Contact if any name	Home Phone	Work Phone	Cell Phone
_____	_____	_____	_____
Primary Health Insurance Carrier	Group ID Number	Policy Holder's Name	ID Number
_____	_____	_____	_____
Camper's Primary Care Physician	Physicians Location	Phone	Fax
_____	_____	_____	_____

No contact allowed with _____

Medical Information (by parent)

Allergies _____

Activity Restrictions _____

Dietary Restrictions? _____

Eating Disorder? _____

Threatened or attempted suicide? _____

Notes for the nurse: _____

Parents are also encouraged to write a separate note to the cabin counselor to be delivered and discussed upon arrival.

Camper's Name: _____ Date of Birth: _____ Session _____ Year _____

Page 2

PARENTS: Please report answers to the following for your camper.

Recent illness or injury: _____

Recent hospitalization: _____

Infectious / communicable disease: _____

Have wheezing or shortness of breath? _____

Seizures: _____

Loss of Consciousness: _____

Diabetes: _____

Other chronic condition: _____

Had fainting or dizziness: _____

Passed out or had chest pain during exercise: _____

Had problems falling asleep or sleep walking: _____

Back or joint pain: _____

Skin Problems: _____

Abnormal Menstruation: _____

Have a history of bed wetting or incontinence: _____

Problems with diarrhea or constipation: _____

Traveled outside the US in the last 9 months: _____

Swimming Ability: _____

Behavior Issues: _____

Emotional Issues: _____

ADD / ADHD: _____

Chronic Fears: _____

Family Issues: _____

Personal crisis: _____

Permission to treat: By my signature below I give my permission to the representatives of Camp Turner to seek out and authorize emergency medical treatment including ordering x-rays or other routine tests, or surgical treatment that may be considered necessary or advisable in the event that I cannot be reached in a reasonable amount of time. I authorize any licensed physician or medical center chosen by representatives of Camp Turner to treat my child. I agree to the release of any records necessary for insurance purposes. I agree that my health insurance will be the primary payer for all medical care, treatments, legal services or other necessary services received by or performed on my child while in the care of Camp Turner or its agents.

I agree to allow my camper's pediatrician to release medical records including immunization records and results of most recent physical to Camp Turner via the camp's Registered Nurse.

By the signature below, I attest that all the information is **complete** and **accurate** to the best of my knowledge and belief. I understand that this information is confidential and will only be shared with those in direct care of my child.

Signature of Parent or Legal Guardian

Printed Name

Date Signed

Page 3

Physician's Office, please:

- **Attach current Immunization Records.**
- **Attach most recent physical.**
- **Complete medication authorization below / or provide written orders.**
- **Sign / stamp the bottom of this page.**

Camp Turner's Registered Nurses must have written orders from the physician to administer prescription OR over-the-counter medications. The orders may be written below, or provided on the physician's letterhead or script. Medication will only be accepted in original containers. All medications are locked in the infirmary and administered under the supervision of our nurses.

Circle "YES" to authorize OR circle "NO" to disallow

Drug	Use	Approval	Comments, recommendations, restrictions
Tylenol or children's Tylenol.	Pain / fever / headache	Yes / No	
Ibuprofen or children's Ibuprofen	Pain / fever / headache	Yes / No	
Tums	Upset stomach	Yes / No	
Benadryl or equivalent	Allergic reaction, insect bites, ALLERGY reactions.	Yes / No	
Cetirizine HCL (Zyrtec)	Allergy Relief	Yes / No	
Loratadine (Claritin)	Allergy Relief	Yes / No	
Cough Drops	Sore or scratchy throat	Yes / No	
Sore Throat Spray	Sore or scratchy throat	Yes / No	
Band Aid Cleansing Foam (or similar)	Cleaning cuts or scrapes	Yes / No	
Triple Antibiotic Cream	Apply to cuts or scrapes	Yes / No	
Burn gel (after ice)	Sunburn other minor burns	Yes / No	
Desitin (zinc oxide cream)	Rash (self-administered by camper)	Yes / No	
Caladryl lotion	Insect bites, plant reactions	Yes / No	
Tussin DM	Cough	Yes / No	
Benzocaine (Sting Ease / After Bite)	For insect bites after icing.	Yes / No	
Miralax / Clearlax	For Constipation	Yes / No	
Sunscreen	Prevent sunburn – self-administered by camper with staff assistance as needed.	Yes / No	
Insect Spray	Prevent insect bites – self-administered by camper with staff supervision and assistance as needed.	Yes / No	

Physician's orders for medications not listed above including **both prescription and over-the-counter medication** (NOTE: we need **written orders for all over-the-counter medications** and **supplements**, including **vitamins, melatonin, sunscreen**, if the camper is to take it at camp)

Medication	Route	Dose	Schedule	Diagnosis – Reason for taking

Camper's Name: _____ Date of Birth: _____ Session _____ Year _____

Medication	Route	Dose	Schedule	Reason for taking

This patient's last physical exam was on _____
Date

At the time of this examination this patient is:

_____ Recommended for a highly active overnight camping program. Participation poses no
Foreseeable health risk to this patient OR to others living, eating and sleeping in proximity

_____ Recommended for participation with **restrictions** or limitations listed here or above:

_____ NOT RECOMMENDED for participation in an overnight camping program involving strenuous
outdoor play, or may pose a risk to others living, eating or sleeping in close proximity.

Printed Name of Healthcare provider Signature Date

Location Phone Number

Physicians Stamp:

**COMPLETE OVER-THE-COUNTER
MEDICATION AUTHORIZATION ABOVE!**

Attach Physical and Immunization Records!