SPROUT CREEK FARM
34 Lauer Road
Poughkeepsie, NY 12603

CAMPER HEALTH INFORMATION FORM

Parent completes Sections 1 - 4

Section 1: Campers Name:

_____

Section 2: Health Insurance Information

Health Insurance Carrier:

_____

Health Insurance Policy Number:

_____

Health Insurance Group Number:

_____

Section 3: Additional Information

Is there anything else you would like us to know about your child?

_____

_____

_____

_____

_____

Section 4:

_____

Parents Signature Date

_____

Over the Counter Medication and Prescription Medicine Form

(Formulario de Medicamentos Sin Receta y Con Receta para que el Doctor complete.)

SPROUT CREEK FARM- INDIVIDUALIZED ORDER FORM
34 LAUER ROAD, POUGHKEEPSIE, NY 12603
TEL: 845-485-8438 FAX: 845-454-6158

Name: _____ **DOB:** _____

The following form must be completed and signed by the child's provider. If the child will be taking any prescription medication while at camp, the provider must also complete the reverse side of this form. Camp nurses are only permitted to dispense medications to a child that is listed on this form by the child's doctor.

The Camp Nurse (RN) will call the prescriber, as allowed by HIPAA, if a question arises about the camper and/or the camper's medication(s).

STANDARD OVER THE COUNTER/PRN MEDICATIONS (the following medications are available in the Infirmary and will be administered at the discretion of a RN, if approval is indicated by the camper's healthcare provider):

Drug Name	Route	Dosage	Indications	Health Care Provider Order	Comments
Tylenol (or generic)	PO (Chewable, elixir, or tabs) PR (suppository)	Per label instructions by age/weight	Pain or fever	Yes No	
Ibuprofen	PO (Chewable tabs, suspension, or tabs)	Per label instructions by age/weight	Pain or fever	Yes No	
Robitussin (or generic)	PO (Syrup)	Per label instructions by age/weight	Cough	Yes No	
Pepto-Bismol (or generic)	PO (Liquid, or chewable tabs)	Per label instructions by age/weight	Upset stomach, diarrhea	Yes No	
Tums	PO (Tabs)	Per label instructions by age/weight	Nausea, upset stomach	Yes No	
Children's Mylanta (or generic)	PO (Chewable tabs)	Per label instructions by age/weight	Upset stomach, constipation	Yes No	
Sunscreen *See recommendations below	If possible, avoid products containing Oxybenzone (Avobenzone ok), parabens, pthalates, & octinoxate.	Per label instructions by age/weight	For sun exposure	Yes No	Self-directed/self-carry (Parent provides)
Insect Repellent *See recommendations below	If using Deet containing products, apply to sneakers and clothing only	Per label instructions	For prevention of insect bites	Yes No	Self-directed/self-carry (Parent provides)
Menthol Cough Lozenges	PO	Per label instructions	Coughing, sore throat	Yes No	
Dimetapp (or generic)	PO (Elixir or tabs)	Per label instructions by age/weight	Nasal congestion, seasonal allergy symptoms	Yes No	
Benadryl (or generic)	PO/Topical (Elixir, chewable tabs or pills) (Topical ointment)	Per label instructions by age/weight	Allergic reactions, (hives, insect bites)	Yes No	

(CONTINUE ON OTHER SIDE)

Antibiotic Ointment	Topical	Per label instructions	Superficial cuts/abrasions	Yes No	
Hydrocortisone Cream	Topical	Per label instructions	Allergic reactions (contact dermatitis, insect bites)	Yes No	
Calamine Lotion (or generic)	Topical	Per label instructions	Allergic reactions, (hives, insect bites)	Yes No	
Other		Per instructions		Yes No	

Prescription Medications (Please complete with the patient's current regimen for both scheduled and PRN medications):

Drug Name	Route	Dosage and Schedule	Indications	Camper Health Care Provider Order	Comments

Additional Orders: (As deemed necessary by health care provider to be implemented by a RN)

_____

_____

Camper's Health Care Provider's Name: _____ Phone #: _____

Type/Print Name: _____

Address: _____ License#: _____

Signature: _____ Date: _____

*Sunscreens and insect repellents may disrupt endocrine hormones, and can promote cancer as well as other medical problems.
(Los protectores solares y los repelentes de insectos pueden alterar las hormonas endocrinas y promover el cáncer y otros problemas médicos.)

Suggested sunscreen brands: Badger Sport, Goddess Garden, Vanicream, Bare Republic, etc.
(Marcas sugeridas de protección solar: Badger Sport, Goddess Garden, Vanicream, Bare Republic, etc.)

Suggested insect repellents without pesticides per Consumer Reports: Repel (oil of lemon eucalyptus), Picaridin 20%, Aunt Fannies Mosquito Repellent Wipes, etc.
(Repelentes de insectos sugeridos sin pesticidas por Consumer Reports: repele (aceite de eucalipto de limón), Picaridin 20%, toallitas repelentes de mosquitos de la tía Fannies, etc.)

Sprout Creek Farm Camper Health Information Form

SECTIONS 5-12 MUST BE COMPLETED BY THE CHILD'S DOCTOR

Child's last name: _____ **Child's first name:** _____ MI:____

Child's date of birth: ____/____/____ Gender: ☐ M ☐ F
Month Day Year

5) CHILD'S DOCTOR INFORMATION

Doctor's full name: _____

Doctor's address: _____

Doctor's telephone (: ___-___-____ **Doctor's fax (**: ___-___-____

6) ALLERGIES

List all known allergies that this child has and **describe reaction and authorized management** of the reaction in each case:

Medication allergies (e.g. penicillin): _____

Environmental allergies (e.g. pollen): _____

Food allergies (e.g. peanuts): _____

7) ASTHMA INFORMATION

Does this child have asthma/RAD? ☐ No ☐ Yes – please fill out the rest of this section

How often does this child have attacks? _____

Last date in emergency room: ____/____/____
Month Day Year

8) IMMUNIZATION & HEALTH HISTORY

~~**Please give all dates of immunization for:** *(Or attach photocopy of official record)*~~

Vaccine	**Dates:** Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP	____	____	____	____	____	____
TD (tetanus/diphtheria)	____	____	____	____	____	____
Tetanus	____	____	____	____	____	____
Polio	____	____	____	____	____	
MMR	____	____				
or Measles	____	____	*or Mumps*		____	____
or Rubella	____	____				
Haemophilus influenza B	____	____	____	____		
Hepatitis B	____	____	____			
Varicella (chicken pox)	____	____				
Meningococcal meningitis	____	____				

Which of the following diseases has this child had?
☐ Measles
☐ Chicken pox
☐ German measles
☐ Mumps
☐ Hepatitis
☐ Tuberculosis
☐ Rheumatic fever

TB Mantoux Test
Date of test: ___ / ___ / ___
Result: ☐ Negative ☐ Positive
If positive, chest x-ray result: _____
Is child on TB meds? ☐ No ☐ Yes

Has this child been diagnosed with ADD or ADHD?
☐ No ☐ Yes

Which of the following has this child had a history of?
☐ Sickle Cell ☐ Lyme Disease ☐ Diabetes
☐ Seizure Disorder ☐ Heart Disease

Sprout Creek Farm Camper Health Information Form

Child's last name: _____ **Child's first name:** _____ MI:____

Child's date of birth: ____/____/____ Gender: ☐ M ☐ F
Month Day Year

9) ROUTINE MEDICATIONS → One of the following must be checked

☐ This child takes NO medications on a routine basis.

OR Please list ALL medications taken routinely (including over-the counter or nonprescription drugs).

☐ This child routinely takes medications as follows:

Medication name	Route	Dose	Frequency	Diagnosis

PARENTS: Please make sure your child brings all listed medications to the bus station and enough to last the entire trip. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

10) OTHER AUTHORIZED MEDICATIONS

The following medications are available in the camp infirmary or first aid station and will be dispensed at the discretion of an RN, if approval is indicated by the camper's healthcare provider. As this child's doctor, you should check (☑) *Yes* or *No* beside **each and every** medication listed below to indicate whether or not we can dispense the drug when necessary. *For all medications, the dosage, schedule and route will be as per the label instructions and – for ingested medications – by age and/or weight.*

Drug Name	Indications	Can be used?	Comments
Tylenol (or generic)	Pain or fever	☐ Yes ☐ No	
Ibuprofen	Pain or fever	☐ Yes ☐ No	
Robitussin (or generic)	Cough	☐ Yes ☐ No	
Chloraseptic (or generic)	Sore throat	☐ Yes ☐ No	
Children's Pepto-Bismol (or generic)	Upset stomach, diarrhea	☐ Yes ☐ No	
Children's Mylanta (or generic)	Upset stomach	☐ Yes ☐ No	
Visine (or generic)	Eye redness / irritation	☐ Yes ☐ No	
Sudafed (or generic)	Nasal congestion / Eustachian tube congestion	☐ Yes ☐ No	
Claritin (or generic)	Nasal congestion / Seasonal allergy symptoms	☐ Yes ☐ No	
Benadryl (or generic)	Allergic reactions (hives, insect bites)	☐ Yes ☐ No	
Antibiotic Ointment	Superficial cuts / abrasions	☐ Yes ☐ No	
Hydrocortisone Cream	Allergic reactions (contact dermatitis, insect bites)	☐ Yes ☐ No	
Calamine Lotion (or generic)	Allergic reactions (hives, insect bites)	☐ Yes ☐ No	

11) HEALTH EXAMINATION

BP: _____ Weight: _____ Height: _____ Observations or unsatisfactory findings: _____

REQUIRED → In my opinion, this child ☐ **IS** / ☐ **IS NOT** able to participate in a physically active program, including swimming.

Restrictions are as follows: _____

12) DOCTOR'S SIGNATURE

I certify that the medical history and background of this child is correct, and that he or she has medical clearance to engage in all activities, except the ones noted on this form.

REQUIRED

Signature: _____

REQUIRED

Date of examination: ____/____/____
Month Day Year

Doctor's stamp