



# CHIPINAW @ SILVER LAKE MEDICAL FORM

Page 1 & 2 are to be filled out by *parents*. Page 3 & 4 to be filled out by *physician* and returned to our office by May 15th.

Session: July  August

Name \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ Age at camp \_\_\_\_\_  
*Last First* Gender:  Male  Female

Home Address \_\_\_\_\_  
*Street Address City State Zip*

Mother's Name \_\_\_\_\_ Home Phone \_\_\_\_\_

Cell # \_\_\_\_\_ Work Phone \_\_\_\_\_ Email Address \_\_\_\_\_

Father's Name \_\_\_\_\_ Home Phone \_\_\_\_\_

Cell # \_\_\_\_\_ Work Phone \_\_\_\_\_ Email Address \_\_\_\_\_

### Emergency Contact

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone ( \_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone ( \_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

Physician / Pediatrician \_\_\_\_\_ Phone ( \_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

Orthodontist \_\_\_\_\_ Phone ( \_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

Dentist \_\_\_\_\_ Phone ( \_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

Is your child currently receiving any form of medical treatment or taking any medication?  Yes  No

If yes, Please explain \_\_\_\_\_

Name of physician treating for above \_\_\_\_\_ Phone ( \_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

| Health History (Please check all that apply)      |  |
|---|--|
| <input type="checkbox"/> ADD / ADHD               | <input type="checkbox"/> Pneumonia       |
| <input type="checkbox"/> Ear Infections           | <input type="checkbox"/> Headaches       |
| <input type="checkbox"/> Glasses / Contact Lenses | <input type="checkbox"/> Nose Bleeds     |
| <input type="checkbox"/> Heart Disease / Defect   | <input type="checkbox"/> Chicken Pox     |
| <input type="checkbox"/> Seizure Disorder         | <input type="checkbox"/> Sleepwalking    |
| <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Bedwetting      |
| <input type="checkbox"/> Asthma                   | <input type="checkbox"/> Eating Disorder |
| <input type="checkbox"/> Surgeries _____          |  |
| <input type="checkbox"/> Other _____              |  |

| Allergies (Please check all that apply)                                    |   |
|--|---|
| <input type="checkbox"/> Penicillin  | <input type="checkbox"/> Animal Dander      |
| <input type="checkbox"/> Sulfa   | <input type="checkbox"/> Dairy              |
| <input type="checkbox"/> Aspirin   | <input type="checkbox"/> Insect Stings      |
| <input type="checkbox"/> Hay Fever   | <input type="checkbox"/> Peanut / Nut _____ |
|  | <input type="checkbox"/> Food _____         |
| <input type="checkbox"/> Other _____                                       |   |
| Describe Reaction: _____   |   |
| Requires Epi-Pen: <input type="checkbox"/> Yes <input type="checkbox"/> No |   |

### Insurance Information

Is the camper covered by family medical/hospital insurance?  Yes  No

If so, indicate carrier or plan name: \_\_\_\_\_ ID#: \_\_\_\_\_

Group #: \_\_\_\_\_ Prescription Plan #: \_\_\_\_\_

Name of insured: \_\_\_\_\_ Relationship to camper: \_\_\_\_\_

Social Security # and date of birth of family member who is named on insurance plan: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Please include a photo copy of  
**Health Insurance card** here

Please include a photo copy of  
**Prescription Medication Card** here

### Parents Authorization

#### Permission to Provide Necessary Treatment or Emergency Care

(MUST be completed before your child can be admitted to camp)

I/We, the custodial parent(s) of \_\_\_\_\_, a minor, do hereby authorize Chipinaw at Silver Lake, or any authorized representative of the Camp to act as my/our agent(s). I hereby give permission to the medical personnel selected by Chipinaw at Silver Lake to:

Order X-rays, routine tests, and treatment

Duplicate and release any records to appropriate personnel for insurance and treatment purposes

Provide or arrange necessary related transportation for my child

In the event I/we cannot be reached in an emergency, I hereby give permission to any licensed physician or surgeon selected by the camp director to secure and administer treatment, including hospitalization, for the person named above.

It is understood that this authorization is given in advance of any specific need for treatment but is given to provide authority on the part of the aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the physician in the exercise of his best judgement may deem advisable.

I/we further give my permission for all pertinent health information to be duplicated and released to the appropriate personnel for treatment.

This authorization shall remain effective until August 16, 2010 unless sooner revoked in writing and delivered to said agent(s).

This health history is correct and complete as far as I know and the person herein described has permission to engage in all camp activities except as noted. This completed form may be photocopied for trips out of camp.

**Parent(s) Signature** \_\_\_\_\_ **Date** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Physician's Section** (Pages 3 & 4 to be completed by a licensed physician.)

New York State law requires the following information to be provided prior to a camper's admission to camp. This form needs to be filled out within 6 months of the start of camp. If there are any changes to medical history or medication, this information needs to be forwarded to the camp health center immediately.

PLEASE PRINT

Camper's Name \_\_\_\_\_ Age \_\_\_\_\_ Gender:  Male  Female  
Last First

Date of examination \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (Must be within a year of the first day of camp)

B/P \_\_\_\_ / \_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_ Urine \_\_\_\_\_ Vision \_\_\_\_\_

**Immunization Record:**

|                      |  |  |  |  |  |  |
|----------------------|--|--|--|--|--|--|
| <b>DTaP</b>          |  |  |  |  |  |  |
| <b>Polio</b>         |  |  |  |  |  |  |
| <b>Pevnar</b>        |  |  |  |  |  |  |
| <b>HiB</b>           |  |  |  |  |  |  |
| <b>Hep B</b>         |  |  |  |  |  |  |
| <b>MMR</b>           |  |  |  |  |  |  |
| <b>Varicella</b>     |  |  |  |  |  |  |
| <b>Hep A</b>         |  |  |  |  |  |  |
| <b>Meningococcal</b> |  |  |  |  |  |  |

**\*Need 4 Polio by 6 yrs old**

Allergies \_\_\_\_\_

Significant Medical History \_\_\_\_\_

Special Dietary Restrictions \_\_\_\_\_

Activity Restrictions (if any) \_\_\_\_\_

**Current Medication** (All daily medication prescriptions must be sent to CampMeds Inc. for proper packaging. Not complying with this policy will incur a \$100 handling fee.)

If camper takes any **daily** or **as needed** medication, they must be listed, otherwise the medicine will not be given.

- This person takes NO medication on a routine basis.
- This person takes medication as follows:

| Medication | Dosage | Times taken each day | Reason for Taking |
|------------|--------|----------------------|-------------------|
|            |        |                      |                   |
|            |        |                      |                   |
|            |        |                      |                   |

- This person takes growth hormone treatments.

Identify any medication taken during the school year that participant does/may not take during the summer:

\_\_\_\_\_

New York State Law requires this section to be filled out by a physician in order for our nurse to dispense over the counter non-prescription medication to your child when needed. **Yes or No must be circled for each drug.**

**Standard Over the Counter / PRN Medications** (meds available in the infirmary/first Aid Kit; to be administered at the discretion of an RN)

| DRUGS                            | ROUTE                                  | DOSAGE                                  | SCHEDULE   | PROVIDER ORDER | COMMENTS |
|----------------------------------|--|---|--|----------------|----------|
| Acetaminophen                    | PO<br>(chewable tabs, elixir, or tabs) | Per label Instructions by, age / weight | q 4 hr prn pain or temp > 100.3                    | Yes / No       |          |
| Ibuprofen                        | PO<br>(chewable tabs, elixir, or tabs) | Per label Instructions by, age / weight | q 6 hr prn pain or temp > 100.3                    | Yes / No       |          |
| Robitussin                       | PO<br>(chewable tabs, elixir, or tabs) | Per label Instructions by, age / weight | q 4 hr prn cough                                   | Yes / No       |          |
| Tums, Maalax, Children's Mylanta | PO<br>(chewable tabs, elixir, or tabs) | Per label Instructions by, age / weight | BID - TID prn upset stomach                        | Yes / No       |          |
| Dramamine                        | PO<br>(chewable tabs, elixir, or tabs) | Per label Instructions by, age / weight | q 6 - 8 hr prn motion sickness                     | Yes / No       |          |
| Dimetapp                         | PO<br>(chewable tabs, elixir, or tabs) | Per label Instructions by, age / weight | q 4 - 6 hr prn nasal congestion, drainage          | Yes / No       |          |
| Benadryl                         | PO<br>(chewable tabs, elixir, or tabs) | Per label Instructions by, age / weight | q 6 hr prn allergic reaction (hives, insect bites) | Yes / No       |          |
| Hydrocortisone                   | Topical Cream                          | Per label Instructions by, age / weight | BID prn rash                                       | Yes / No       |          |
| Triple Antibiotic                | Ointment                               | Per label Instructions by, age / weight | BID prn minor bacterial infections                 | Yes / No       |          |

**Parents:** Please note, we provide the above "as needed" over the counter medications free of charge. Therefore there is no need for you to send them through CampMeds or with your camper.

*I have examined the patient herin described and have reviewed the health history. It is my opinion that this child is physically able to engage in the regular camp activities, except as noted.*

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

Please Print Name \_\_\_\_\_ Phone # \_\_\_\_\_

Please Return To:



Camp Chipinaw  
52 Silver Lake Road  
Swan Lake, New York 12783  
845-583-8600



# CHIPINAW@SILVER LAKE



52 Silver Lake Road Swan Lake New York 12783

845-583-8600

Dear Parent:

I am writing to inform you about meningococcal disease, a potentially fatal bacterial infection commonly referred to as meningitis, and a new law in New York State. On July 22, 2003, the New York State Public Health Law (NYS PHL) was amended to include §2167 requiring overnight children's camps to distribute information about meningococcal disease and vaccination to the parents or guardians of all campers who attend camp for 7 or more nights. This law became effective on August 15, 2003.

Chipinaw @ Silver Lake is required to maintain a record of the following for each camper:

- A response to receipt of meningococcal meningitis disease and vaccine information signed by the camper's parent or guardian; AND
- Information on the availability and cost of meningococcal meningitis vaccine (Menomune™); AND EITHER
- A record of meningococcal meningitis immunization within the past 10 years; OR
- An acknowledgement of meningococcal meningitis disease risks and refusal of meningococcal meningitis immunization signed by the camper's parent or guardian.

Meningitis is rare. However, when it strikes, its flu-like symptoms make diagnosis difficult. If not treated early, meningitis can lead to swelling of the fluid surrounding the brain and spinal column as well as severe and permanent disabilities, such as hearing loss, brain damage, seizures, limb amputation and even death.

Cases of meningitis among teens and young adults 15 to 24 years of age have more than doubled since 1991. The disease strikes about 3,000 Americans each year and claims about 300 lives.

A vaccine is available that protects against four types of the bacteria that cause meningitis in the United States - types A, C, Y and W-135. These types account for nearly two thirds of meningitis cases among teens and young adults.

Information about the availability and cost of the vaccine can be obtained from your health care provider and by visiting the manufacturer's website at [www.meningitisvaccine.com](http://www.meningitisvaccine.com).

Please complete the Meningococcal Vaccination Response Form and return it to our winter address with the rest of the forms that need to be returned.

To learn more about meningitis and the vaccine, please consult your child's physician. You can also find information about the disease at the New York State Department of Health website: [www.health.state.ny.us](http://www.health.state.ny.us), and the website of the Center for Disease Control and Prevention (CDC): [www.cdc.gov/ncidod/dbmd/diseaseinfo](http://www.cdc.gov/ncidod/dbmd/diseaseinfo).

Sincerely,

# MENINGOCOCCAL MENINGITIS VACCINATION RESPONSE FORM

New York State Public Health Law requires the operator of an overnight children's camp to maintain a completed response form for every camper who attends camp for seven (7) or more nights.

**Check one box and sign below.**

My child has had the meningococcal meningitis immunization (Menomune™) within the past 10 years. Date received: \_\_\_\_\_

[Note: The vaccine's protection lasts for approximately 3 to 5 years. Revaccination may be considered within 3-5 years.]

I have read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that my child will not obtain immunization against meningococcal meningitis disease.

Signed: \_\_\_\_\_  
(Parent / Guardian)

Date: \_\_\_\_\_

Camper's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Parent/Guardian's E-mail address (optional): \_\_\_\_\_

Dear Camp Parents,

This summer Chipinaw at Silver Lake will continue work with **CampMeds, Inc**, a pre-packaged medication program to dispense and package your child's medication for camp. Camp families are **required** to register with **CampMeds** if your child takes any medicine while at camp. The **CampMeds** pharmacy will dispense ALL of your child's prescription and non-prescription medicine taken daily or as needed. This includes vitamins. All pills will be individually packaged in sealed packets labeled with your child's name, medicine, dosage, date and time to be given. Medication not in pill form (liquids, inhalers, drops, etc), will be dispensed as well. Our system ensures that each camper receives their correct medicine at the correct time. All medicine will be shipped to camp prior to your child's arrival.

**What you need to do:**

1. Register on [www.CampMeds.com](http://www.CampMeds.com) (you may register prior to obtaining prescriptions)
2. Note the Camper ID # you will receive when registered. Print out receipt at the end registration.
3. Obtain original prescriptions written for 30 day increments. (Refer to FAQ #11)
4. Write Camper ID # on top corner of prescriptions. \*Do not send us medication, only the written RX
5. Prescriptions are filled as written. It is your responsibility to confirm all prescriptions are written correctly; exactly how and when your child takes the medication (daily or PRN), that the correct med is prescribed and the dosing is correct. (Refer to FAQ #2 and #15).
6. If your child attends camp over 30 days, prescriptions must have a refill. Unused meds are sent home from camp
7. **For Controlled Substances:** If your child is staying longer than 30 days, law requires a new prescription for each 30 day supply. Two separate 30 day Rx's are required for Controlled Substances. No refills and only 30 days of meds should be written on the prescription. Send all prescriptions together
8. Non-prescription meds/vitamins; physician's authorization or written directions by parent required.
9. Include a copy of both sides of your insurance/prescription card.
10. Mail prescriptions, registration receipt and copy of insurance card directly to:  
**CampMeds** PO Box 267037, Ft. Lauderdale, FL 33326-7037

**Fees:** There is a one-time registration fee for the entire summer which will be charged to your credit card immediately upon registration. \*\*Fees are per camper, not prescription, and do not include the cost of medicine.

- **Fee for campers attending up to 30 days of camp is \$50 including shipping**
- **Fee for campers attending over 30 days of camp is \$60 including shipping**

If your camper requires **NON-PILL MEDS ONLY** (liquids, inhalers etc) there is a one- time fee of \$30 per camper instead of above packaging fee.

**Deadlines:** Children attending camp **June 27**; above items must be received no later than **May 27**.

Children attending camp **July 22**; above items must be received no later than **June 22**.

**A \$25 late fee** will be charged to your credit card if any of the items above are received after deadlines.

Please be aware that your credit card will be charged the shipping cost for any med change or if additional meds are ordered and sent to camp after your initial medication and/or refills have been sent.

**Email Notification:** You are notified by email when **CampMeds** receives your online registration, when your prescriptions are received and when meds are sent to camp. Contact us if you do not receive a confirming email within one week of sending prescriptions.

**Insurance/Prescription Meds:** The **CampMed's** licensed pharmacy partner accepts most insurance plans. They will verify your insurance upon registration and submit to your plan once camp begins. You are responsible for all co-payments, deductibles and meds not covered by your insurance. \*\*All of your med charges will appear on your credit card statement from the Pharmacy usually after your child returns home. You are responsible to notify **CampMeds** of any changes to your credit card and/or insurance plan. If the pharmacy is not a provider for your plan, we will notify you to arrange alternative arrangements.

**OTC Items and Meds Not Covered by Insurance:** Will be charged to your credit card by the Pharmacy.

Please refer to our website [www.CampMeds.com](http://www.CampMeds.com) for registration and important details. For questions contact **CampMeds** at 954-577-0025 or [info@CampMeds.com](mailto:info@CampMeds.com). **Please review the following FAQ's.**