Medical Information

Name (First): Name (Last): Birth date: Age: Sex: F

Parent or guardian: Relationship to counselor:

Home Address: Home Phone:

City: State: OUTSIDE USA Zip Code:

Phone (Business): (Cell): (Fax): E-mail:

Second Parent or guardian (or spouse): Relationship to counselor:

Home Address: Home Phone:

City: State: OUTSIDE USA Zip Code:

Phone (Business): (Cell): (Fax): E-mail:

Emergency Contact (other than Parent/Guardian):

Home Address: Home Phone:

City: State: OUTSIDE USA Zip Code:

Phone (Business): (Cell): (Fax): E-mail:

HEALTH HISTORY:

Has this applicant ever required psychiatric counseling or hospitalization: No

Surgery/serious injury or hospitalization date(s) :

Disability or recurring illness:

Allergies: Dietary modification:

Is the counselor able to do all camp activitie No Explain:

Any modifications:

Medications to be dispensed at camp?

Medications MUST remain in the original container.

Dentist and/or Orthodontist: Phone:

Name of family physician: Date of last exam:

Address: Office Phone:

(For females) has the counselor menstruated: No If no has she been told about it? No

Family Medical/Hospital Insurance Company:

Counselor Name:

Insurance Information **Photocopy of front and back of health insurance card must be attached to this form.**

Carrier Policy or Group Number: Subscriber ID:

ID Number from card

Address: Office Phone:

Health Examination
Section to be completed by Licensed Physician:

Date Examined:

☐ I have examined the applicant.

☐ In my opinion, the applicant's condition does not preclude his/her participation in an active camp program

The applicant is under the care of the physician for the following condition(s):

Current treatment (include current medications):

Explanation of any reported loss of consciousness, convulsion, or concussion:

Does applicant have Diabetes? Does applicant have epilepsy?

Recommendations and Restrictions while at camp:

Any treatment to be continued at camp:

Any medications to be administered at camp (specific dosages):

Any medically prescribed meal plan or dietary restrictions:

Any allergies (food, drugs, plants, insects, etc.):

Licensed Physician's Name: Signature:

Address: City:

State: OUTSIDE US Zip Code: Phone:

Date of form completion: By:

Initial if completed by nurse or physician's assistant

This health history is correct so far as I know, and the person listed above has permission to engage in all prescribed camp activities except as noted. I hereby give permission to the camp: 1. To provide ongoing health care. 2. To select medical personnel and to order x-rays or routine tests for treatment for the above. EMERGENCY AUTHORIZATION: In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for the person named above. l agree to assume any expenses for medical care given to our child during his/her stay at Hindu Youth Summer Camp.
I understand and agree to comply with any restrictions placed on my participation in the center activities.

SIGNATURE of parent/ guardian or adult staff volunteer: Date

Photocopy of front and back of health insurance card must be attached to this form.

This health history is correct and I've completed all questions and pages to the best of my ability.

The participant named has permission to engage in all the center activities except as noted.

I give permission to the medical personnel selected by HYSC and its officials to provide routine health care, administration of prescribed medications, and the following over-the-counter medications: Benadryl (or similar); hydrocortisone cream; triple antibiotic ointment; Pepto-Bismol (or similar); Tylenol (or similar); and Motrin (or similar). I also give permission for the administration of epinephrine in the event of a severe allergic reaction or asthma attack. Circle any medications you do NOT authorize the staff to administer.

In the event I cannot be reached in an emergency, I give permission for the physician selected by the camp administrator administer treatment to the participant, including hospitalization, if needed.

I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. This completed form may be photocopied for trips out of camp facility.

The participant may be released to the person designated as an emergency contact.

SIGNATURE of parent/ guardian or adult staff volunteer: _____

Date _____

Hindu Youth Summer Camp Consent Form
Permission for Administration of Medication

Please note that you must comply with the following for the welfare of your child should it become necessary to administer medications during the camp. Failure to do so could result in a delay for the child to receive medications in a timely manner.

1. Have your child's physician complete the **Physician's Statement** section of this form in its entirety
2. Complete the **Parent Statement** section of this form in its entirety.
3. All medication, prescribed or over the counter, must be handed over to the camp directors upon arrival to camp.

Physician's Statement

Child's Name: _____

Medication: _____

Dosage: _____

Time: _____

Duration: _____

Possible Side Effects: _____

Reason for Medicine: _____

_____ _____
Physician's signature Date

Parent's Statement

By completing and signing this form, I give permission to my child, _____
to take this medication as prescribed. To help in that assessment, I assess my child to be:

☐ **Self-Directed** (Can recognize medication, knows dose and time of delivery, and can refuse to take the wrong medication from an authority figure)

☐ **Able to Carry and Self-Administer** (as in self-directed, plus understands need to keep medicine supply away from other counselors and safely stored, can recognize when medication supply needs replenishing, can keep track of dosing and timing of medication, knows to seek assistance from health office if medication is not working)

☐ **Non-Self Directed** (Must be reminded and supervised in storage and administration of medication)

_____ _____
Parent Signature Date

Patient's Name: _____ Birth date: _____

Vaccine	Date Given	Site Given	Vaccine Lot Number	Vaccine Manufacturer	VIS Date*	Initials of Vaccine Aelministrator	Signature of Parent or Guardian
DTaP 1							
DTaP2							
DTaP3							
DTaP4							
DTaP5							
IVP 1							
IVP 2							
IVP 3							
IVP 4							
1.1Jv!R 1							
1.1Jv!R 2							
Hib 1							
Hib 2							
Hib 3							
Hib 4							
Td							
HepB 1							
HepB 2							
HepB 3							
Prevnar 1							
Prevnar 2							
Prevnar 3							
Prevnar 4							
Verivax							
Hib/Hep B 1							
Hib/Hep B 2							
Hib/Hep B 3							

*Vaccine Information Statement
record Publication Date of VIS in this column

Initials/Signature of Vaccine Dispensers

_____ _____