



## **INSTRUCTIONS FOR COMPLETING YOUR MEDICAL FORMS**

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### **PLEASE READ CAREFULLY**

Camps Equinunk and Blue Ridge require that medical forms be received by the camp office a **minimum of 30 days prior to attendance at camp**. In order to comply with medical insurance guidelines relating to annual physicals, we recommend you call your doctor's office **NOW** and schedule an appointment for your camp physical.

Please remember the following:

1. Sign and date the Authorization Statement page
2. Attach a legible copy of the front AND back of your Medical Insurance card and Prescription Plan card.

Send all completed medical forms no later than **May 20th** to:

**Camps Equinunk & Blue Ridge**  
**PO Box 808**  
**East Hampton, NY 11937**

**PLEASE NOTE: Non-compliance to this mandatory requirement of the American Camping Association and our insurance company will terminate your registration.**

If you have any questions regarding these forms please call Caralyne in the camp office at 631 329 3239



# Camps Equinunk and Blue Ridge Medical Form

2009

Staff: \_\_\_\_\_

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

## GENERAL INFORMATION

Age: \_\_\_\_\_

Mother: \_\_\_\_\_ Father: \_\_\_\_\_

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

Cell Phone: \_\_\_\_\_

Gender:  Male  Female

Work Phone: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Other Phone: \_\_\_\_\_

## SUMMER/VACATION RESIDENCE

Phone: \_\_\_\_\_

Date Range: \_\_\_\_\_ thru \_\_\_\_\_

## EMERGENCY CONTACTS

Contact 1:

\_\_\_\_\_

Relationship:

\_\_\_\_\_

Contact 2:

\_\_\_\_\_

Relationship:

\_\_\_\_\_

Phones (Home, Cell, Work):

\_\_\_\_\_

\_\_\_\_\_

## FAMILY HEALTH CARE PROVIDERS

Primary Physician / Pediatrician: \_\_\_\_\_

Phone (with area code): \_\_\_\_\_

Name of Dentist: \_\_\_\_\_

Phone (with area code): \_\_\_\_\_

Name of Orthodontist: \_\_\_\_\_

Phone (with area code): \_\_\_\_\_

Name of Mental Health Provider: \_\_\_\_\_

Phone (with area code): \_\_\_\_\_

## HEALTH INSURANCE

Insurance Carrier: \_\_\_\_\_

Carrier Address: \_\_\_\_\_

Carrier City/State/Zip: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Group Number: \_\_\_\_\_

Name of Insured: \_\_\_\_\_

Relationship: \_\_\_\_\_

Prescription Plan Carrier: \_\_\_\_\_

Prescription Plan Number: \_\_\_\_\_

Insured's SSN or Insurance ID: \_\_\_\_\_

# Camps Equinunk and Blue Ridge Medical Form

2009

Staff: \_\_\_\_\_

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

## HEALTH HISTORY

Indicate the following by entering an approximate date of last occurrence.

### Diseases

Chicken Pox:	_____	Asthma:	_____
Measles:	_____	Hepatitis A:	_____
German Measles:	_____	Hepatitis B:	_____
Mumps:	_____	Hepatitis C:	_____

### Allergies (Non-Dietary):

No Known Allergies

Hay Fever

Other Allergies:

Ivy Poisonings, etc.

Insect Stings

Penicillin

Epi-Pen

### Dietary Allergies:

No Known Allergies

Peanut

Flat Fish

Wheat

Lactose Intolerant

Tree Nuts

Citrus

Whey

Artificial Sweeteners

Mustard

Seafood

Shellfish

Glucose

### Other Dietary Allergies or Comments:

### Dietary Preferences:

No dietary preferences

Vegetarian

Kosher

No Poultry

No Eggs

No Seafood

Vegan

No Pork

No Dairy

No Red Meat

### Additional Dietary Considerations:

### Substance Abuse

Please describe briefly if applicable:

# Camps Equinunk and Blue Ridge Medical Form

2009

Staff: \_\_\_\_\_

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

## GENERAL HEALTH QUESTIONS

Please check any that apply and explain in the area below

- |  |   |
|--|---|
| <input type="checkbox"/> Frequent Headaches                  | <input type="checkbox"/> Emotional problems referred to treatment |
| <input type="checkbox"/> Frequent ear infections             | <input type="checkbox"/> Orthodontic appliance required at camp   |
| <input type="checkbox"/> Back problems                       | <input type="checkbox"/> Glasses, contact, protective eyewear     |
| <input type="checkbox"/> Diarrhea/Constipation               | <input type="checkbox"/> Bed wetting                              |
| <input type="checkbox"/> Seizures/Convulsions                | <input type="checkbox"/> Diabetes                                 |
| <input type="checkbox"/> Bleeding/Clotting                   | <input type="checkbox"/> Heart murmur                             |
| <input type="checkbox"/> Head Injury                         | <input type="checkbox"/> Knocked unconscious                      |
| <input type="checkbox"/> Eating disorder                     | <input type="checkbox"/> Skin problems (itching, rash)            |
| <input type="checkbox"/> Passed out during or after exercise | <input type="checkbox"/> Problem with joints (ankles, knees)      |
| <input type="checkbox"/> Dizzy during or after exercise      | <input type="checkbox"/> Sleep walking                            |
| <input type="checkbox"/> Chest pain during or after exercise | <input type="checkbox"/> High blood pressure                      |
| <input type="checkbox"/> Mononucleosis in the past 12 months | <input type="checkbox"/> Acne                                     |
| <input type="checkbox"/> Abnormal Menstrual History          |   |

Enter an explanation for any of the above in the area below:

Operations or serious injuries (with dates):

Chronic or recurring illness:

Other diseases or additional information about the above:

# Camps Equinunk and Blue Ridge Medical Form

2009

Staff: \_\_\_\_\_

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

## MEDICATIONS

This person takes no medications

Send enough medication to last while your child is at camp! Keep it in the original packaging. If a prescription, the label should include the drug, dosage, time(s) of delivery and physician's name.

If the applicant is to take medications routinely at camp, including over-the-counter or nonprescription drugs, please enter these medications one at a time.

### Medication

Enter the medical or 'common name' for the medication:

### Dosage

Enter number in milligrams (mg), or number of tablets, puffs, etc.:

### Prescribing Physician:

### Phone (For U.S.: xxx-xxx-xxxx)

### Delivery:

Breakfast  Lunch  Dinner  Bedtime  Other(specify: )

### Reason for taking:

### Medication

Enter the medical or 'common name' for the medication:

### Dosage

Enter number in milligrams (mg), or number of tablets, puffs, etc.:

### Prescribing Physician:

### Phone (For U.S.: xxx-xxx-xxxx)

### Delivery:

Breakfast  Lunch  Dinner  Bedtime  Other(specify: )

### Reason for taking:

# Camps Equinunk and Blue Ridge Medical Form

2009

Staff: \_\_\_\_\_

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

## MEDICATIONS

### Medication

Enter the medical or 'common name' for the medication:

### Prescribing Physician:

### Dosage

Enter number in milligrams (mg), or number of tablets, puffs, etc.:

### Phone (For U.S.: xxx-xxx-xxxx)

### Delivery:

Breakfast  Lunch  Dinner  Bedtime  Other(specify: )

### Reason for taking:

### Medication

Enter the medical or 'common name' for the medication:

### Prescribing Physician:

### Dosage

Enter number in milligrams (mg), or number of tablets, puffs, etc.:

### Phone (For U.S.: xxx-xxx-xxxx)

### Delivery:

Breakfast  Lunch  Dinner  Bedtime  Other(specify: )

### Reason for taking:

### Medication

Enter the medical or 'common name' for the medication:

### Prescribing Physician:

### Dosage

Enter number in milligrams (mg), or number of tablets, puffs, etc.:

### Phone (For U.S.: xxx-xxx-xxxx)

### Delivery:

Breakfast  Lunch  Dinner  Bedtime  Other(specify: )

### Reason for taking:

# Camps Equinunk and Blue Ridge Medical Form

2009

Staff: \_\_\_\_\_

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

## MENTAL/EMOTIONAL HEALTH

- No Mental Health Issues**
- Diagnosed with Attention Deficit Disorder (ADD or AD/HD)
- Diagnosis of depression, OCD, panic/anxiety disorder
- Significant learning or processing challenge (disability)
- Currently seen by professional for mental/emotional health concerns
- Treated with medication for mental/emotional problem
- Other emotional health concern

## Comments:

## IMPORTANT

**If any of the above are checked, please have the mental health professional send a written statement to the camp describing:**

- a) The condition and treatment plan, including any medications
- b) Any behavior at camp that indicates to our staff that the applicant needs a professional referral
- c) A recommendation for participation in our camp program

**If medication for any of the above has been prescribed, also provide:**

- d) Certification that the applicant has been taking the same medication at the same dose for 3 months prior to the start of camp
- e) If (d) is not true, a detailed explanation for the change in medication

# Camps Equinunk and Blue Ridge

2009

## Medical Insurance and Prescription Cards

Staff Name: \_\_\_\_\_

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

Please photocopy both sides of your family's insurance prescription card and attach it here. The prescription card will be used if your child requires prescription medication this summer.

**PLEASE ENSURE COPIES ARE LEGIBLE**

**Medical Insurance Card (Front)**

A large, empty rectangular box with a thin black border, intended for pasting the front side of a medical insurance card.

**Medical Insurance Card (Back)**

A large, empty rectangular box with a thin black border, intended for pasting the back side of a medical insurance card.

**Prescription Card (Front)**

A large, empty rectangular box with a thin black border, intended for pasting the front side of a prescription card.

**Prescription Card (Back)**

A large, empty rectangular box with a thin black border, intended for pasting the back side of a prescription card.

**Camps Equinunk and Blue Ridge  
Parent / Staff Authorization Form**

**2009**

Staff: \_\_\_\_\_

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

**Please notify the camp if this person is exposed to any communicable disease during the three weeks prior to camp attendance.**

**AUTHORIZATION STATEMENT**

(This Authorization must be signed for attendance)

By my signature below, I certify the following:

The Health History is complete and correct to the best of my knowledge. The person named has permission to engage in all camp activities except where noted. I hereby give permission to the camp to provide, seek, and consent to routine healthcare, administration of prescribed medications, and emergency treatment for me/my child as may be necessary, including but not limited to x-rays, routine tests and treatment, and/or hospitalization. In the event that the pharmacy/doctor does not accept my medical/drug card, I hereby authorize Camps Equinunk & Blue Ridge to charge the credit card on file or bill my account accordingly for such charges. I also give permission for the camp to arrange related transportation. I agree to the release of any records necessary for treatment, referral, billing or insurance purposes.

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

I understand that part of the camp experience involves activities and group living arrangements and interactions that may be new to my child, and that they come with certain risks and uncertainties beyond what my child may be used to dealing with at home.

I am aware of these risks, and I am assuming them on behalf of my child. I realize that no environment is risk-free, and so I have instructed my child on the importance of abiding by the camp's rules, and my child and I both agree that he or she is familiar with these rules and will obey them.

**Signature of Staff Member:** \_\_\_\_\_

**Printed Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

***NOTE: If Staff Member is under 18 yrs of age we MUST have a Parent/Guardian signature***

**Parent Signature:** \_\_\_\_\_

**Printed Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

# Camps Equinunk and Blue Ridge IMMUNIZATION

**2009**

Staff: \_\_\_\_\_

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

## IMMUNIZATION

Please record the date of basic immunizations and the most recent booster doses.

Name	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
Diphtheria	_____	_____			
Pertussis (Whooping cough) DPT	_____	_____	_____	_____	_____
Tetanus	_____	_____			
<hr/>					
Polio	_____	_____	_____	_____	
Haemophilus influenza B	_____	_____	_____	_____	
Hepatitis B	_____	_____	_____	_____	
Varicella (Chicken pox)	_____	_____			
<hr/>					
MMR	_____	_____			
or Measles	_____	_____			
or Mumps	_____	_____			
or Rubella	_____	_____			

TB Mantoux Test \_\_\_\_\_  Positive

If Positive and greater than 10mm, date and results of chest X-ray \_\_\_\_\_

Course of Treatment/Medication \_\_\_\_\_

Has this person ever tested positive for HIV?  Yes  No

# Camps Equinunk and Blue Ridge Physician's Examination

2009

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State: \_\_\_\_\_

Sign and return to:  
Camps Equinunk & Blue Ridge  
PO Box 808  
East Hampton, NY 11937

This examination should be performed within 12 months of arrival at camp. Examination for some other purpose within this period is acceptable. Examination is for determining fitness to engage in strenuous activity.  
Codes: V – Satisfactory X – Not satisfactory (Explain) O – Not examined

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Heart: \_\_\_\_\_ B.P.: \_\_\_\_\_  
Hct/Hgb Test: \_\_\_\_\_ If appropriate  
Urinalysis: \_\_\_\_\_  
Eyes: \_\_\_\_\_ Ears: \_\_\_\_\_ Nose: \_\_\_\_\_ Throat: \_\_\_\_\_ Lungs: \_\_\_\_\_  
Glasses: \_\_\_\_\_ Extremities: \_\_\_\_\_ Genitalia: \_\_\_\_\_ Abdomen: \_\_\_\_\_ Hernia: \_\_\_\_\_  
Skin: \_\_\_\_\_ Posture: \_\_\_\_\_

Allergy (Please specify): \_\_\_\_\_

General Appraisal: \_\_\_\_\_

Is this person up to date on all routine childhood immunizations? \_\_\_\_\_ Date of last tetanus shot: \_\_\_\_\_

### FOR GIRLS AND WOMEN

Has this person menstruated? \_\_\_\_\_ If not, has she been told about it? \_\_\_\_\_

If so, is her menstrual history normal? \_\_\_\_\_

Special considerations: \_\_\_\_\_

### RECOMMENDATIONS AND RESTRICTIONS WHILE AT CAMP

Special Diet: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Swimming / Diving: \_\_\_\_\_

Strenuous Activity: \_\_\_\_\_

Other: \_\_\_\_\_

I have examined the person herein described and have reviewed the health history. It is my opinion that this person is physically able to engage in camp activities, except as noted above.

\_\_\_\_\_  
(Examining Physician)

\_\_\_\_\_  
(Telephone)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Address)