Easterseals New Jersey - Camping and Recreation
21 O'Brien Rd · Hackettstown, NJ 07840 · Phone (908) 852-3896
Fax (908) 852-9263 · www.eastersealsnj.org/camp

Participant Health and Medical Form 2018-2019

Medication must be in multi-dose continuous feed sealed packaging from an authorized pharmacy: Genoa Pharmacy, Bald Eagle Pharmacy or LTC Scripts. Medications must arrive to camp two weeks prior to program.

Participant Information

Note: Prescriptions or authorizations for special needs or accommodations from a primary care provider is a requirement for DDD-affiiliated persons.

Last Name	First Name	Middle Name	
Street	Email		
City	State	Zip	County
Dates will attend camp from (mm/dd/yy) to	Date of Birth (mm/dd/yy) / /	Age during camp	☐Male ☐Female

Primary Person to contact in case of illness or injury ★★ Individual can provide additional health information★★

Name	Relationship to participant	Preferred phone	Alternative phone
		- -	- -

Additional emergency contact in the event primary contact can not be reached

Name	Relationship to participant	Preferred phone	Alternative phone
		- -	- -
Name	Relationship to participant	Preferred phone - -	Alternative phone - -

Medical insurance information

This participant is covered by family medical/hospital insurance ☐ Yes ☐ No

Include a copy of your insurance card if appropriate; copy both sides of the card so information is readable.

Primary Insurance Company	Primary Policy Number	Subscriber	Primary Insurance Phone Number
Secondary Insurance Company	Secondary Policy Number	Secondary Subscriber	Secondary Insurance Phone Number

Health care provider's contact information:

Name of the participant's primary doctor(s):	Preferred phones - -
Name of the participant's dentist:	Preferred phones - -
Name of the participant's orthodontist(s):	Preferred phones - -

Allergies

☐ No known allergies

☐ Food
☐ Medication
☐ To the environment (insects/seasonal/etc)
☐ Other Allergies

Describe below what the participant is allergic to and the reaction seen and recommended treatment:

Diet / Nutrition

☐ The participant eats a regular diet
☐ The participant eats a vegetarian diet
☐ The participant has special food needs

Describe below the participant's special diet:

Restrictions / Limitations

☐ I have reviewed the program and activities of the camp and feel the participant can participate without restrictions
☐ I have reviewed the program and activities of the camp and feel the participant can participate with the described restrictions or adaptations

Describe below any participant's restrictions/limitations
(i.e., if participant uses special equipment such as wheelchair, leg braces, helmet, walker, etc., please provide instructions for use; physician perscription):

★Authorization for Healthcare (to be signed by Legal Guardian or Authorized Representative)

This health history is correct and accurately reflects the status of the participant's to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the participant's to order x-rays, routine tests, and treatment related to the health of participant's for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize secure proper treatment for and order injections, anesthesia, or surgery for this participant. I understand the information on this form will be shared on a "need to know" basis with participant's staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of participant's health record from providers who treat said participant and these providers may talk to the programs staff about participant's health status. By signing below, I acknowledge that all medication information provided is complete and accurate, a physician has reviewed the medication information, and I have read and understood all policies regarding medication administration. I understand and accept the risks to the participant from not being fully immunized.

Signature of Legal Guardian/Representative: ______________________ **Date:**____________ **Relationship:** ____________

If for religious or other reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance.

★Licensed Professional Health Provider (to be signed by Licensed Healthcare Provider)

I have reviewed the participant's health history, and have discussed the camp program with the participant's caregiver(s). It is my opinion that the participant is physically fit to participate in an active camp program (except as noted).

Name of licensed provider: __________________ **Signature**: __________________ **Title**: _____ **Date:** __________

Office Address: ____ Telephone: ____________
Street City State Zip Code

Routine Medication **ALL MEDICATIONS MUST BE HAND WRITTEN ON THIS FORM OR ON PHARMACY MAR SHEET ATTACHED ONLY**

MEDICATION ADMINISTRATION POLICY

- Medication is any substance a person takes to maintain and/or improve his/her health. This includes vitamins & natural remedies.
- This form **MUST** include all medications and treatments prescribed including lotions, dietary supplements, inhalers, liquids, allergy medications, g-tube feedings and PRN or temporarily prescribed medications.
- A new form should be completed when medication changes occur and must be reviewed by physician.

PLEASE FOLLOW DIRECTIONS

- **Medication must arrive in multi-dose packaging & packaged by time of day. If your pharmacy does not provide this, choose one of our pharmacies: Genoa Pharmacy 973-658-6685, Bald Eagle Pharmacy, 973-728-4600, or LTC Scripts, 844-572-7478.**
  Medication must arive to camp two weeks prior to the start of the campers program.
  Ask your physician for vacation scripts for medications. The pharmacy will fill & deliver your medication to camp for you. By obtaining Specific vacation scripts your normal billing or refill cycles should not be affected. Additional Information can be found in your confirmation packet.
- Prescription medications must COME FROM THE PHARMACY in original pharmacy packaging and have a pharmacy label that matches the doctor's orders on this form. Mislabeled or hand-written packaging cannot be accepted. Medications in sample packs, foreign medications and with labels not in English cannot be administered.
- All routine OTC medications and supplements must be sent in original product packaging and proper administration must be indicated on this form.
- Medications that are not packaged as indicated, including but not limited to, unlabeled pre-poured medications and medications with incorrect label information cannot be accepted and participants CANNOT AND WILL NOT be admitted into the program.
- Medication must be supplied for the length of stay plus one day (7 day supply for a 6 day program, etc.) Participant without the appropriate medication supply will not be admitted to the program.
- Medication administration times are typically: 8:30am, 12:30pm, 5:30pm and 8:30pm – other times may be accommodated.

☐ **This participant will not take any daily medications while attending camp.**
☐ **This participant will take the following medication(s) while at camp:**

ALL MEDICATIONS MUST BE HAND WRITTEN ON THIS FORM OR ON PHARMACY MAR SHEET ATTACHED ONLY
Scripts must be provided for any changes after the medication forms have been submitted.

Medication and dose	Dosage at each time given	Time	Route and special instructions (crush pills, give w/ applesauce, etc.)

Other Notes: (Please note any specific instructions regarding possible side effects, duration of time to be administered, activity limits, etc.)

Please copy if more than 10 medications are to be given or additional forms can be downloaded from website: www.eastersealsnj.org/camp

PRN Medications

The following over-the-count “OTC” medications are stocked for all programs and are listed as standing orders for the symptoms indicated. Personal OTC medication supplies are not needed unless it is taken as a routine medication. Please mark appropriate OTC medications to administer and indicate when the PRN/OTC should be given.

Headaches / Minor Pain / Fever
- ☐ Tylenol (Acetaminophen)
- ☐ Advil (Ibuprofen)
- ☐ Aleve (Naproxen Sodium)
- ☐ Midol
- ☐ Other: _____

Coughs / Colds / Sore Throat
- ☐ Sudafed (Pseudoephedrine)
- ☐ Medicated Throat Spray
- ☐ Dayquil (or generic)
- ☐ Nyquil (or generic)
- ☐ Robitussin (or generic)
- ☐ Throat lozenges
- ☐ Other: _____

Constipation *Intervene after _____ days without a movement
- ☐ Milk of Magnesia
- ☐ Decussate Sodium
- ☐ Dulcolax Tablets
- ☐ Glycerin Enema
- ☐ Glycerin or Dulcolax Suppositories
- ☐ Miralax (or generic)
- ☐ Metamucil (or generic)
- ☐ Other: _____

Allergic Reaction / Insect Bites
- ☐ Calamine Lotion
- ☐ Benadryl Cream / Gel (or generic)
- ☐ Benadryl Tablet (or generic)
- ☐ Children’s Benadryl (or generic)
- ☐ Hydrocortisone Cream
- ☐ Other: _____

Diarrhea / Upset Stomach / Indigestion
- ☐ Mylanta (generic)
- ☐ Pepto Bismo Tablets or Liquid (or generic)
- ☐ Imodium AD (or generic)
- ☐ TUMS
- ☐ Other: _____

Sun Exposure / Sun Burn Prevention and After Care
- ☐ Hypo-allergenic sunscreen SPF 50+
- ☐ Aloe Vera
- ☐ Other: _____

Motion Sickness
- ☐ Dimehydrinate (Dramamine)
- ☐ Meclizine HCL (Dramamine Less Drowsy)
- ☐ Other: _____

Other:
- ☐ Bacitracin
- ☐ Anti-Fungal Cream
- ☐ Diaper Rash Cream

Additional PRN / Over The Counter Information:

Immunization History

Provide the month and year for each immunization. **Starred (★) immunizations must be current and provided prior to acceptance into any program.** Copies of immunization forms from health care providers or state or local governments are acceptable; please attach to this form.

Immunization	Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most Recent Month/Year
Diphtheria, tetanus, pertussis ★ (DTaP) or (TdaP)						
Tetanus booster ★ (dT) or (TdaP)						
Mumps, measles, rubella ★ (MMR)						
Polio ★ (IPV)						
Haemophyilus influenza type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (Chicken pox) ☐Had chicken pox Date: _____						
Meningococcal meningitis (MCV4)						
Tuberculosis (TB) Test	Date:		☐ Negative	☐ Positive		

Additional Immunization Information:

General Health History: Check "Yes" or "No" for each statement; Please explain "Yes" answers in the space below

Has/does the participant:

1. **Ever been hospitalized?**...................................... ☐ Yes ☐ No
   When:____________________
   Reason:____________________
2. **Ever had surgery?**.. ☐ Yes ☐ No
   When:____________________
   Reason:____________________
3. **Have recurrent/chronic illness?**.......................... ☐ Yes ☐ No
4. **Had a recent infectious disease?**...................... ☐ Yes ☐ No
5. **Had a recent injury?**... ☐ Yes ☐ No
6. **Had asthma / wheezing/shortness of breath?**... ☐ Yes ☐ No
   Effects:____________________
7. **Have diabetes?**.. ☐ Yes ☐ No
8. **Had seizures?**... ☐ Yes ☐ No
   Last known:____________________
   Type of Seizure:____________________
9. **Have headaches?**.. ☐ Yes ☐ No
10. **Wears glasses, contacts or protective eye year?** ☐ Yes ☐ No
11. **Had fainting or dizziness?**.. ☐ Yes ☐ No
12. **Passed out/had chest pain during exercise?** …………… ☐ Yes ☐ No
13. **Had mononucleosis** (**"mono"**) **during the past 12 months?** ☐ Yes ☐ No
14. **If female, had problems with periods/menstruation?**....... ☐ Yes ☐ No
15. **Have problems with going to sleep/sleepwalking?**.......... ☐ Yes ☐ No
    Sleeping Routine:____________________
16. **Ever had back/joint problems?**... ☐ Yes ☐ No
17. **Have a history of bedwetting?**... ☐ Yes ☐ No
18. **Have problems with diarrhea/constipations?**.................... ☐ Yes ☐ No
    BM Routine: ____________________
    Intervene after:____________________
19. **Have any skin problems?**.. ☐ Yes ☐ No
20. **Traveled outside the country in the past 9 months?**........ ☐ Yes ☐ No
    Destination:____________________

Mental, Emotional, and Social Health: Check "Yes" or "No" for each statement

Has/does the participant:

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)?.............................. ☐ Yes ☐ No
2. Ever been treated for emotional or behavior difficulties or an eating disorder?... ☐ Yes ☐ No
3. During the past 12 months, seen a professional to address mental/emotional health concerns? .... ☐ Yes ☐ No
4. Had a significant life event that continues to affect the participant's life? .... ☐ Yes ☐ No
   (History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)

Please explain "Yes" answers in the space below, noting the number of the question. The camp may contact you for additional information

Additional Information

Please provide in the space below any additional information about the participant's health that you think important or that may affect the participant's ability to fully participate in the camp program. **Attach additional information if needed.**

☐ Behavioral support plan enclosed ☐ Camper's last physical enclosed ☐ Caregiver's notes and suggestions enclosed

Note to Participants & Caregivers

Complete and send this form back to Easterseals Camping and Recreation, 21 O'Brien Road, Hackettstown, NJ 07840 at least 2 weeks prior to your event along with the medications; pharmacies will send medications so that you do not need to pick up and send yourself if you so choose. It is advised that you photocopy this form for your records and bring a copy to each program you'll be attending.

Participant's Health and Medical forms will not be accepted without the correct signatures from caregivers and licensed medical providers Form is valid for 12 months following date of licensed medical professional review and signature.