Camp Arevelk 2023 Medical Packet

Please read through these forms carefully as there are new requirements in order to comply with the New York Board of Health. Doctor appointments are needed- please book with the appropriate timing.

This information provides camp health care personnel the background to provide appropriate care based on the individual's needs. Keep a copy of the completed packet for your records. Any changes to this packet should be provided to camp health care personnel upon the participant's arrival in camp. The State of New York Board of Health requires that we have all necessary medical forms onsite prior to the start of camp. Any camper whose medical forms are not received by the registrar by July 23rd, 2023 **WILL NOT** be able to participate in camp this year.

ALL returning campers must fill out a NEW form each year with current information, date and signatures.

*The information on this form will be kept in strict confidence. It will be used only to meet the needs of your child or in an emergency.

PLEASE NOTE: Forms C and D must be completed by a medical professional, with a signature or stamp at the bottom of Form D verifying completion. Without these completed and signed forms, a participant will not be permitted to attend camp.

A. Emergency and Insurance Information

Participant Name:	Date of Birth:
Parent Name:	Parent Phone Number:
Emergency Contact Name: (if parent not reached)	Emergency Contact Phone Number:

Do you carry any family medical/hospital insurance/OHIP? ☐ Y ☐ N

If so, indicate carrier or plan name: ____________________________________

Group #: ____

Name and Date of Birth of individual who carries the plan:____

DOB:____________________

Camp Arevelk 2023 Medical Packet

B. Participant Health History Form

The following information can be filled in by the parent/guardian of a minor or by an adult staff member.

Participant's Name: ____

ALLERGIES: List all known allergies (medical, food, or other), as well as the reaction and management of the allergy.

____

____

____

____

Has/Does the participant:	Yes	No	Has/Does the participant:	Yes	No
1. Have any recent injury, illness or infectious disease?			16. Ever had back problems?		
2. Have chronic or recurring illness/condition?			17. Ever had problems with joints (e.g. knees, ankles)?		
3. Ever been hospitalized?			18. Have an orthodontic appliance?		
4. Ever had surgery?			19. Have any skin problems (e.g. itching, rash, acne)?		
5. Have frequent headaches?			20. Have diabetes?		
6. Ever had a head injury?			21. Have asthma?		
7. Ever been knocked unconscious?			22. Have mononucleosis in the past 12 months?		
8. Wear glasses, contacts, or protective eyewear?			23. Have problems with diarrhea/constipation?		
9. Ever had frequent ear infections?			24. Have problems with sleep walking?		
10. Ever passed out during or after exercise?			25. If female: Have abnormal menstrual history?		
11. Ever been dizzy during or after exercise?			Age of first menses:_______________		
12. Ever have seizures?			26. Have a history of bed-wetting?		
13. Ever had chest pain during or after exercise?			27. Ever had an eating disorder?		
14. Ever had high blood pressure?			28. Ever sought professional help for emotional difficulties?		
15. Ever been diagnosed with a heart murmur?					

Please explain any "yes" answers from the above general questions, noting the number of each question:

____

____

____

____

____

Please provide <u>honest</u> information about the participant's <u>behavior</u> and <u>physical</u>, <u>emotional</u>, or <u>mental health</u> of which the camp should be aware in order to meet his/her individual needs: (Include helpful accommodations)

____

____

____

____

____

Camp Arevelk 2023 Medical Packet

C. Examination and Immunization Form

The following information must be completed by a Licensed Medical Professional.

Name:____was examined on_______/________/_________
Height:____________________________Weight:____________________________BP: ___________________________

Name of Family Dentist/Orthodontist:__________________________________Phone: ___________________________
Dentist/Orthodontist Address: ____

1. In my opinion, the above individual______IS______IS NOT able to participate in an active camp program.

2. Describe all conditions for which the participant may be under the care of a physician. Note any limitations and/or restrictions while at camp. All medications and treatments prescribed should be listed on Form D:

____
____
____

3. Please list any medically-prescribed meal plan or dietary restrictions:

____
____
____

4. Please check off any of the following that the participant has had:

______Measles
______Chicken Pox
______German Measles
______Mumps

______Hepatitis A
______Hepatitis B
______Hepatitis C
______COVID-19

______TB Mantoux Test
Date of last test: ____________
Result:______Positive
______Negative

5. Please complete the box below, OR attach a printed immunization record from your doctor's office:

All dates of immunization for:	**Mo/Yr**	**Mo/Yr**	**Mo/Yr**	**Mo/Yr**	**Mo/Yr**	**Mo/Yr**	**Mo/Yr**	**Mo/Yr**	**Mo/Yr**
COVID-19 (Pfizer / Moderna / J&J)									
Diptheria Tetanus (DTaP)									
Hepatitis A (HepA)									
Hepatitis B (HepB)									
Haemophilus Influenzae B (HIB)									
Influenza									
Measles Mumps Rubella (MMR)									
Pneumococcal (PCV13/PPSV23)									
Polio (IPV)									
RotaVirus									
Varicella - *Chicken Pox* (Var)									

D. Standing Orders for the Administration of Medications Form

The following information must be completed by a Licensed Medical Professional.

In order to administer medications at St. Vartan Camp / Hye Camp, our Diocesan Summer Camps require an authorized prescriber's (MD, PA, APRN) written order **and** a parent or guardian's authorization for the nurse or camp personnel to administer medications. Medications must be in **the original pharmacy prepared containers** and **labeled with the name of the child**, name of the drug, strength, dosage, frequency, authorized prescriber's name and date of the original prescription. Any modifications to the prescription bottle instruction must have a signed doctor's note. All medications will be returned on the final day of camp; medication that is not picked up on the last day of camp will be destroyed.

PARTICIPANT NAME: ____

Prescription Medications and Treatments

Please complete with current regimen for both scheduled and as-needed medications, in addition to any other orders deemed necessary to be implemented by the camp nurse (i.e., dressing changes, cast care, special dietary instructions).

Medication	Dose, Route, and Frequency	Indication, other comment(s)

Standard Over-the-Counter Medications, First Aid, and Preventative Treatment

The brand or generic equivalent medication listed below is available at camp, so please DO NOT bring the below medications to camp. Over-the-counter medication and treatment will be administered at the nurse's discretion, ONLY if approval is indicated by the participant's licensed medical professional with a distinct ***√ Check Mark*** *to the left of the item.*

	Acetaminophen (e.g. Tylenol)		Ibuprofen, (e.g. Advil, Motrin)		Naproxen (e.g. Aleve)
	PMS/Menstrual Relief (e.g. Midol, Pamprin)		Body Powder (e.g. Gold Bond)		Dietary Fiber (e.g. Metamucil, Benefiber)
	Cough Medication (e.g. Robitussin, Nyquil)		Decongestant (e.g. Dimetapp, Sudafed)		Antihistamine (e.g. Benadryl, Claritin)
	Throat Spray (e.g. Chloraseptic)		Cough Drops (e.g. Halls)		Canker Sore Relief (e.g. Orajel)
	Antacid (e.g. Tums, Mylanta, Maalox)		Anti-diarrheal (e.g. Imodium, Pepto Bismol)		Laxative (e.g. Milk of Magnesia, Dulcolax)
	Antiseptic Cleanser (e.g. Bactine)		Antibiotic Ointment (e.g. Neosporin)		Steroidal Ointment (e.g. Hydrocortisone)
	Topical Antihistamine (e.g. Benadryl, Caladryl)		Sun care (e.g. Sunscreen, Aloe Vera, Solarcaine)		Bug Repellent (e.g. Off!)
	Eye Drops/Lubricant (e.g. Visine)		Swimmer's Ear Drops (e.g. Auro-Dri, Swim Ear)		Athletes Foot Care (e.g. Tinactin)

I have completed and verified the medical information on Form C and Form D.

Signature of Licensed Medical Professional: ______________________________

Printed: ______________________________ **Date:** ______________

Address: ____

Phone: ______________________________ **Fax:** ______________________________

I HAVE READ THE ABOVE STATEMENTS AND AGREE TO THEIR TERMS.

Parent/Guardian/Staff Signature: ______________________________ **Date:** ______________

Camp Arevelk 2023 Medical Forms

Checklist: Did you complete the following items?

☐ A- Emergency and Insurance information
☐ B- Participant Health History
☐ C- Examination and Immunization - *Must be completed by a Licensed Medical Professional*
☐ D- Administration of Medications Form-*Must be completed by a Licensed Medical Professional*

Signature of Parent/Guardian: ____Date: ___________

Please print, scan and email sent to CampArevelk@gmail.com

If necessary, printed forms can be sent to:
Camp Arevelk
65 Kinnicutt Rd.
Worcestor, MA 01602

For questions contact us at CampArevelk@gmail.com or at +1 (905)-597-5967 (CDN #)