Pine Bush Bible Camp Medical Form (page 1 of 2)

76 Bible Camp Rd Bloomingburg, NY 12721
phone (845) 361-1871 fax(845) 361-4752

Name _____ DOB_____ Home Phone_____

Address _____ City _____ State _____ Zip _____

Mother's Name _____ Father's name _____

Mother's cell _____ work _____ Father's cell _____ work _____

IN CASE OF EMERGENCY and parent or guardian can NOT be reached NOTIFY

Name _____ Relationship _____

Home phone _____ Cell phone _____ Work _____

Does the person have any of the following: **please circle yes or no**

Rheumatic fever	YES	NO	Epilepsy	YES	NO	Seizures/Convulsion	YES	NO
Severe Earache	YES	NO	Sickle Cell	YES	NO	Kidney Disease	YES	NO
Skin disease/Eczema	YES	NO	Heart Disease	YES	NO	Cerebral Palsy	YES	NO
Lyme's disease	YES	NO	Diabetes	YES	NO	Chicken Pox	YES	NO
ADD/ADHD	YES	NO	Asthma	YES	NO	Hernia	YES	NO
Aggressive behavior	YES	NO	Hayfever	YES	NO	Lung disease	YES	NO
Emotional concerns	YES	NO	Bee allergy	YES	NO	Peanut/Nut allergies	YES	NO
Serious poison ivy, oak or sumac	YES	NO				Other Allergies	YES	NO

PLEASE list food, medications or other allergies here:_____

IF circled YES to any of the above please explain when and the extent (attach extra paper as needed):

_____

_____

Does the person have frequent:

Sore throat	YES	NO	Sinus trouble	YES	NO	Constipation	YES	NO
Sleepwalking	YES	NO	Bed wetting	YES	NO	Nosebleeds	YES	NO
Bronchitis	YES	NO	Upset stomach	YES	NO	Fainting spells	YES	NO

For female CAMPERS: has the camper menstruated? YES NO If NO, has she been told about it YES NO If yes, is her menstrual history normal? YES NO Does she experience severe cramping or need special consideration? YES NO IF YES please explain _____

FOR ALL CAMPERS AND STAFF (under 18) MUST ATTACH A COPY OF IMMUNIZATION RECORD
(must include DPT, Polio, MMR, Varicella, Hep B, HIB and Meningiococcal meningitis)
Adult Staff (over 18 yrs old) please indicate date of last TD booster _____
Mantoux date: _____ Results: NEGATIVE or POSITIVE IF positive please indicate chest xray date, xray results and any treatment received: _____

Note: PBBC medical insurance has limitations based upon your family's medical insurance. Any medical cost incurred while at PBBC that is in excess of $100 MUST BE submitted to your medical carrier for payment. If there is any portion of the cost unpaid by your medical insurance carrier, those costs will be submitted to PBBC's insurance carrier **PLEASE ATTACH A COPY OF YOUR INSURANCE CARD OR MEDICAID CARD**

RELEASE FOR MEDICAL TREATMENT: (If younger than 18 must be signed by a parent or guardian): I hereby grant permission to the staff members at Pine Bush Bible Camp to obtain proper medical diagnosis and treatment for myself/my child by a qualified doctor or hospital in case of sickness or injury while at PBBC.

Date _____ **Signature** _____

PAGE 2 MUST BE COMPLETED AND SIGNED BY A PHYSICIAN FOR EACH CAMPER AND WORKER UNDER 18 YEARS OLD

PINE BUSH BIBLE CAMP

PINE BUSH BIBLE CAMP

NY State Law requires this to **be filled out by a physician** for a nurse to dispense over the counter medications to a child if needed.

Individualized orders for: Camper Name_____ Weight:_____

Standard Over the Counter/PRN Medications (The following medications are available in the health center and will be dispensed at the discretion of an RN, if approval is indicated by the camper's healthcare provider):

Medications	Route	Dosage	Schedule and Indications	Health Care Provider order	Comments
Acetaminophen (Tylenol)	PO (chewable, elixir or tabs)	Per label instructions by age/weight	Q 4 hr for pain or fever	Yes No	
Ibuprofen (Advil, Motrin)	PO (chewable, liquid, tabs)	Per label instructions by age/weight	Q 6 hr for pain or Fever	Yes No	
Robitussin/ Robitussin DM (Guaifensin/ Dextromethorphan Hbr)	PO (syrup)	Per label instructions by age/weight	Q 4 hr PRN for cough	Yes No	
Bismuth (Pepto-Bismol)	PO (liquid or chewable tabs)	Per label instructions by age/weight	Q 30 min to 1 hr PRN	Yes No	
Children's Mylanta	PO (liquid or chewable tabs)	Per label instructions by age/weight	BID-TID PRN stomach upset	Yes No	
Diphenhydramine Hydrochloride (Benadryl)	PO (elixir, chewable, pills)	Per label instructions by age/weight	Q 6 hr PRN for allergic reaction	Yes No	
Pseudoephedrine HCL (Sudafed)	PO (elixir or pills)	Per label instructions by age/weight	Q 4 hr PRN nasal congest/ drainage	Yes No	
Loperamide HCL (Immodium)	PO (liquid, or chewable, pills)	Per label instructions by age/weight	Q 6-8 hours for diarrhea	Yes No	
Lotrimin/Tolfanate	Cream/spray	Per label	Rash/athletes foot	Yes No	
Hydrocortisone	Cream	Per label	Rash, bug bites	Yes No	
Antibiotic Ointment	Cream	Per label	Cuts	Yes No	
Diphenhydramine Hcl (Benadryl)	Cream/gel	Per label	Bug bites	Yes No	
Calamine	Lotion/spray	Per label	Bug bites/rashes	Yes No	
Anbesol	Liquid	Per label	Toothache	Yes No	
Lice Shampoo	Liquid	Per label	Lice	Yes No	
Iodine	Liquid	Per label	Cleanse abrasions	Yes No	
Sting Kill Swabs	Swab/pad	Per label	Bee/Wasp stings	Yes No	
Visine	Drops	Per label	Red itchy eyes	Yes No	
Cough drops	Lozenges	Per label	Sore throat/cough	Yes No	
Phenol (Sore throat spray, Chloraseptic)	Spray	Per label	Sore throat/canker sore	Yes No	

Prescription & OTC Medications (Complete with patient's current regimen for scheduled and PRN meds, use additional paper as needed)

Medication	Route	Dosage	Schedule and Indications	Comments

Additional Orders (as deemed necessary by health care provider to be implemented by an RN; i.e. peak flow, dressing changes, cast care, etc.) Please attach a separate paper for such orders

Physician's Name: _____ Physician Signature: _____

Phone Number:_____ Date:_____