Dunkirk Conference Center

3602 East Lake Road
Dunkirk, New York 14048
(716) 366-1900

Camper Medical History Form

Camper's Name ________________________________ Birthdate ____________________
Street Address ________________________________
City ____ State/Zip Code _______________
Parent/Guardian Name __________________________
*Home Phone _________________________________ *Work Phone ________________
Emergency Contact ____________________________
*Home Phone _________________________________ *Work Phone ________________
Physician's Name ______________________________ Office Phone _________________
Name of Camp Attending (Junior High, Family Camp, etc.) ____________________________________
Dates Attending _______________________________

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Immunizations: Give full dates

MMR:			
Polio:			
Diphtheria:			
Hepatitis B:			
Tetanus:			
Varicella:			
HIB:			

Weight:
Height:
Blood Type (if known):

HIB = Haemophilus Influenzae Type B

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General health status of the camper ____
Able to participate in camp activities? ____
Any activities you wish the camper to refrain from? ____________________________________
Which do you encourage? ____
Swimming ability ____
Diet restrictions? ____
Any other information you feel is pertinent? ____

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Parent's Request

I, the parent or guardian of ____________________(or myself if over age 18) grant my permission to the Dunkirk Conference Center to authorize and obtain medical help from any licensed physician, hospital or medical clinic should the person (or myself) become ill or injured while at camp, if I am not available (or am incapacitiated myself) to give authorization for treatment.

____ __________ ________________
Signature of Parent/Guardian or Self (if over age 18) Date Phone Number

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____ ________________
Insurance Company Name Policy Number

Office Use Only:
Cabin #:
Counselor Name:

Camper Medical History Questionaire

Patient History:

Any problems with the following …	Please circle answer.		Comment as necessary.
1. Have allergies?	Yes	No	To what? __________________
2. Receives allergy shots?	Yes	No	
3. Have asthma?	Yes	No	What Rx given? ____________
4. Have frequent colds?	Yes	No	
5. Have sore throats?	Yes	No	
6. Have frequent stomachaches?	Yes	No	
7. Have ear problems?	Yes	No	
8. Have a hearing loss?	Yes	No	Describe __________________
9. Have ear tubes in place?	Yes	No	In both or one ear? __________
10. Wear glasses or contacts?	Yes	No	
11. Have an orthopedic disorder?	Yes	No	Describe __________________
12. Have frequent headaches?	Yes	No	How often? ________________
13. Have fainting spells?	Yes	No	How often? ________________
14. Have a seizure disorder?	Yes	No	Describe __________________
15. Have diabetes?	Yes	No	Describe __________________
* Insulin dependent?	Yes	No	How often? ________________
16. Have a heart condition?	Yes	No	Describe __________________
17. Have any skin conditions?	Yes	No	Describe __________________
18. Wear dental braces?	Yes	No	
19. Have scoliosis?	Yes	No	
20. Have kidney problems?	Yes	No	Describe __________________
21. Have mental or emotional problems?	Yes	No	
22. Females: Has she menstruated?	Yes	No	
* If yes, any problems?	Yes	No	Describe __________________

23. Have any medical restrictions that would prevent full participation in activities?
Explain if Yes ____

24. Has your child ever been hospitalized for tests, an illness or surgery?
Explain if Yes ____

25. Does any one at home have a medical problem that might affect this child?
Explain if Yes ____

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Only prescription medication that your medical provider has allowed will be admitted into camp. No other medication will be permitted on grounds. All prescription medication must be in the original container that it was given to you by the pharmacist. If prescription medicine must be administered, please fill out the additional sheet provided.

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New York State Guidelines regarding Administration of Medications in Schools/Overnight Camps

Camp nurses and medical personnel are often asked to dispense medication to school children. Medication can only be dispensed under the following policy:

1. A written request from the parent/guardian.
2. A written request from the physician which indicates the frequency and the dosage of the medication.
3. The medication is to be brought in the prescribed labeled bottle by an adult to camp.

Please do not send any over the counter aspirin, cold pills, cough drops, inhalers etc. to camp with your child. The dangers of this practice are possible choking hazards or another child may take the medicine resulting in serious consequences. As stated above, medication will only be dispensed under the described conditions and this will be strictly adhered to within this camp situation.

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Prescription Medication Request

Camper's Name ________________________ Date of Birth _____________________
Address ______________________________ Social Security Number ____________
(Optional)

	Name of Medication	Dose	Route	Time to be Administered
1	______________________________	________	________	____________________
2	______________________________	________	________	____________________
3	______________________________	________	________	____________________
4	______________________________	________	________	____________________
5	______________________________	________	________	____________________

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Parent's Request

Please give ____________________ the above medication as ordered by my medical provider.

____ _________ _______________
Signature of Parent/Guardian or Self (if over age 18) Date Phone Number

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