

Casperkill Camp Programs

Report of Health Examination

Name of Child: _____ Date of Birth: _____

Name of Parents: _____

Address: _____

Home Phone: _____ Mom's Work#: _____ Dad's Work #: _____

Emergency Contact: _____ Phone #: _____

IMMUNIZATIONS

Vaccine	1 st Dose	2 nd Dose	3 rd Dose	Booster	Booster
Diphtheria-Tetanus-Pert					
Diphtheria-Tetanus-Ped					
Diphtheria-Tetanus-Adult					
Trivalent Oral Polio					
Measles			Other Vaccines		
Mumps			HIB		
Rubella					

MAJOR ILLNESSES and OPERATIONS

Physical Examination Date: _____

Height: _____ Percentile: _____

Weight: _____ Percentile: _____

Nutrition: _____

Orthopedic (posture): _____

Orthopedic (feet): _____

Skin: _____

Eyes: _____

Ears: _____

Nose: _____

Tonsils: _____

Teeth: _____

Thyroid: _____

Lymph Glands: _____

Lungs: _____

Heart: _____

Blood Pressure: _____

Pulse: _____

Abdomen: _____

Genitalia: _____

Extremities: _____

Speech: _____

Neurological: _____

GENERAL ASSESSMENT (comments)

Is this child capable of participating in the full program including physical activities?
YES _____ NO _____ If no, how must the program be modified to meet the needs of the child?

Does the child have a history of any allergies? YES _____ NO _____
If yes, list specific allergies along with medication used in treatment.

Other:

Date: _____ Signature of Physician: _____

Physician Full Name: _____

Address: _____

WAIVER and RELEASE STATEMENT

I recognize the risk of illness and injury inherent in participating in any recreational activities, including but not limited to sports, exercise, fitness, aerobics, swimming, summer camp programs and/or transportation programs. I am allowing my child to participate upon the express agreement and understanding that I hereby, for myself, my child, and/or my heirs, executors and administrators, waive and release any and all rights and claims for damages I and/or my child may have against Bright Horizons at Casperkill, and/or the current property owner, their officers, directors, agents subsidiaries, parents, and employees, representatives, successors and assigns for any and all injuries suffered by my child during these programs and/or activities. I give my permission for facility personnel to deliver to call for a doctor, ambulance, or some designated person in case of an emergency. I hereby execute and deliver this Waiver and Release Statement to induce Bright Horizons and the current property owner, their officers, directors, agents, subsidiaries, parents, employees, representatives, successors and assigns to permit my child, named below, to participate in their programs and/or activities.

Please Print Name of Child: _____ Today's Date: _____

Name of Parents (Please Print) : _____

Emergency Contact: _____ Phone #: _____

Parent/Guardian Signature: _____

PICTURE & VIDEO RELEASE WAIVER

Bright Horizons at Casperkill takes still photographs and video of children at our center. Please check if **you do** _____ or **do not** _____ authorize the use and reproduction of any photographs, training videos, slides, negatives or proofs of your child listed above for Bright Horizons' use. These photos may be used within the center, on the Bright Horizons' website, or for other Bright Horizons' use.

Parent/Guardian Signature: _____ Today's Date: _____

Casperkill Camp Programs

Camp Medication Form

Name: _____

Date of Birth: _____ Weight: _____

The following form must be completed and signed by the child's physician. If the child will be taking any prescription medication while at camp, the doctor must also complete the reverse side of this form. Camp Nurses are only permitted to dispense medications to the child that is listed on this form by the child's doctor. EMT and RTE certified staff can supervise the self administration of medication.

OVER THE COUNTER MEDICATIONS: (The following medications are available in the Casperkill Health Office).

Drug Name	Route	Dosage And Schedule	Indications	Camper Health Care Provider Order	Comments
Tylenol (or generic)	PO (Chewable, elixir, or tabs) PR (suppository)	Per label Instructions by Age/weight	Pain or Fever	Yes No	
Ibuprofen	PO (Chewable tabs, suspension, or tabs)	Per label Instructions by Age/weight	Pain or Fever	Yes No	
Robitussin (or generic)	PO (Syrup)	Per label Instructions by Age/weight	Cough	Yes No	
Pepto-Bismol (or generic)	PO (Liquid or chewable tabs)	Per label Instructions by Age/weight	Upset stomach, diarrhea	Yes No	
Kaopectate (or generic)	PO (Liquid ore tabs)	Per label Instructions by Age/weight	Diarrhea	Yes No	
Children's Mylanta (or generic)	PO (Chewable tabs)	Per label Instructions by Age/weight	Upset Stomach	Yes No	
Sudafed (or generic)	PO (Tabs/Liquid)	Per label Instructions by Age/weight	Nasal congestion Eustachian tube congestion	Yes No	
Chlorpheniramine	PO (Chewable tabs, suspension or tabs)	Per label Instructions by Age/weight	Seasonal allergy symptoms	Yes No	
Soothe-A-Sting Swabs	Topical	Per label instructions	Insect Sting (i.e. bee sting)	Yes No	
Dimetapp (or generic)	PO (Elixir or tabs)	Per label Instructions by Age/weight	Nasal congestion Seasonal allergy symptoms	Yes No	
Benadryl (or generic)	PO/Topical (Elixir, chewable tabs or pills / ointment)	Per label Instructions by Age/weight	Allergic reactions (hives, insect bite)	Yes No	
Antibiotic Ointment	Topical	Per label instructions	Superficial cuts/abrasions	Yes No	
Hydrocortisone Cream	Topical	Per label instructions	Allergic reactions (contact dermatitis, or insect bites)	Yes No	
Calamine Lotion (or generic)	Topical	Per label instructions	Allergic reactions (hives, insect bites)	Yes No	

Prescription Medications (Please complete with the patient's current regimen for both scheduled and PRN medications):

Drug Name	Route	Dosage And Schedule	Indications	Camper Health Care Provider Order	Comments

Additional Orders – (As deemed necessary by the health care provider to be implemented by an RN or supervised self administration by an EMT or RTE certified staff member).

Camper's Health Care Provider Name: _____ Phone#: _____

Address: _____ License #: _____

Signature: _____ Date: _____