

# SUMMER PROGRAM HEALTH FORM CHECKLIST

## SUMMER 2010 – Sports

Dear Summer Program Parent/Guardian:

**All parts of pages 1, 2, and 3 must be completed and returned to the Perrella Wellness Center 1 WEEK PRIOR TO ARRIVAL ON CAMPUS:**

Page 1 – **HEALTH EXAMINATION FORM** - to be completed by parent or guardian.  
Complete all sections, being sure to sign and date at bottom of form.

Page 2 - **UPDATED IMMUNIZATION RECORD**

A. 2 MMR dates are mandatory - Measles, Mumps, Rubella

B. If your child is attending programs for 7 nights or more, you will be mailed a Meningococcal Meningitis Vaccination Response Form (2 pages). **This form must be completed and returned with the examination form.**

**PHYSICAL EXAM** – (within past year) **SCHOOL PHYSICAL ACCEPTABLE**

Performed by physician, physicians assistant, or nurse practitioner

Page 3 – **MEDICATION SHEET** – **must be completed for every camper.**

NEW YORK STATE DEPARTMENT OF HEALTH LAW now **requires** that the Health care provider (doctor, nurse practitioner, physicians assistant) must complete the medication sheet for both over-the-counter and prescription medications. Medications will not be dispensed if this form is not completed and signed by parent and health care provider, this includes all over-the-counter medications.

### **IMPORTANT NOTES**

**ALL PRESCRIPTION AND OVER-THE-COUNTER MEDICATION TO BE TAKEN BY CAMP PARTICIPANT (UNDER 18 YRS. OLD) MUST BE LEFT AND KEPT AT THE PERRELLA WELLNESS CENTER WHERE A SCHEDULE WILL BE SET UP FOR DISPENSING OF THE MEDICATION. All MEDICATIONS MUST BE IN THE PHARMACY BOTTLE OR ORIGINAL STORE CONTAINER WITH PROPER LABELING.**

**IT IS ADVISED, PRIOR TO MAILING THESE FORMS THAT YOU MAKE A COPY TO HAND CARRY TO REGISTRATION. NO CAMPER WILL BE ALLOWED TO STAY WITHOUT COMPLETED HEALTH FORMS.**

**ANY QUESTIONS PLEASE CALL THE WELLNESS CENTER AT 607-431-4120.**



**IMMUNIZATIONS REQUIRED FOR REGISTRATION**

**This side to be completed by physician - PLEASE PRINT**

**PATIENT NAME:** \_\_\_\_\_  
**LAST FIRST DOB**

**DIPHTHERIA, TETANUS, PERTUSSIS** (All dates including date of booster after 6 years of age). **DATES** \_\_\_\_\_

**Hib vaccine** **DATES** 1<sup>st</sup> \_\_\_\_\_ 2<sup>nd</sup> \_\_\_\_\_ 3<sup>rd</sup> \_\_\_\_\_ 4<sup>th</sup> \_\_\_\_\_

**Hepatitis B vaccine** **DATES** 1<sup>st</sup> \_\_\_\_\_ 2<sup>nd</sup> \_\_\_\_\_ 3<sup>rd</sup> \_\_\_\_\_

**POLIO VACCINE** (complete series of Oral/Salk) **DATES** \_\_\_\_\_

**MMR** (Mumps, Measles, Rubella) (after 1<sup>st</sup> birthday) **DATES** 1<sup>st</sup> \_\_\_\_\_ 2<sup>nd</sup> \_\_\_\_\_ (Minimum of 28 days after Dose 1)

**VARICELLA VACCINE** **DATE** \_\_\_\_\_ **OR** **DATE OF ILLNESS** \_\_\_\_\_

**MEDICAL EXAMINATION –TO BE FILLED OUT BY LICENSED PHYSICIAN, PHYSICIAN’S ASSIST/NURSE PRACTITIONER**

**This examination must be performed within 12 months** of arrival at camp. Examination for some other purpose within this period is acceptable. Examination is for determining fitness to engage in strenuous activities.

**CODE:** - Satisfactory  x Not Satisfactory (explain)  O Not Examined

**HGT.** \_\_\_\_\_ **WT.** \_\_\_\_\_ **B.P.** \_\_\_\_\_

Eyes _____	Lungs _____
Glasses _____	Abdomen _____
Ears _____	Hernia _____
Nose _____	Extremities _____
Throat _____	Posture (spine) _____
Teeth _____	Skin _____
Heart _____	Allergy _____

Recommendations and restrictions while in camp:

Special Diet \_\_\_\_\_

Medications (identify) \_\_\_\_\_

Dispensing protocol \_\_\_\_\_

Can this camper participate in unrestricted recreational activity?

If no, explain: \_\_\_\_\_

Other: \_\_\_\_\_

I have examined the person herein described and have reviewed his/her health history. It is my opinion that he/she is physically able to engage in camp activities, except as noted above.

Telephone \_\_\_\_\_  
Examining Physician/Physician’s Assist./ Nurse Practitioner

Date \_\_\_\_\_ Address \_\_\_\_\_

**SPORTS MEDICATION SHEET** – Must be completed and signed by Parent AND Health Care Provider

ORDERS FOR: Name \_\_\_\_\_ DOB: \_\_\_\_\_ Weight \_\_\_\_\_

**Standard Over the Counter Medications** (The following medications are available at the College Wellness Center and will be administered at the discretion of an RN or LPN if approval is indicated by the camper's healthcare provider.): Any other over the counter medications the child routinely takes and will be bringing with them must be added to this list. **No over-the-counter medications can be dispensed without completion of this form.**

DRUG NAME	ROUTE (PLEASE CIRCLE PREFERRED FORMULATION(S))	DOSAGE	SCHEDULE AND INDICATIONS	CAMPER HEALTHCARE PROVIDER ORDER	COMMENTS
Ibuprofen	oral	200 mg		Yes No	
Acetaminophen	oral	325 mg		Yes No	
Acetaminophen	Chewable	160 mg		Yes No	
				Yes No	
				Yes No	
				Yes No	
				Yes No	

**Prescription Medications** (Must complete with patient's current regimen for both scheduled and PRN medications use 2<sup>nd</sup> page if needed)

DRUG	ROUTE	DOSAGE	SCHEDULE & INDICATIONS	COMMENTS

**Both signatures required:**

Parent/guardian signature \_\_\_\_\_ Date \_\_\_\_\_

Health Care Provider (MD,NP,PA) Name (print): \_\_\_\_\_ Phone \_\_\_\_\_

Address: \_\_\_\_\_ License# \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_