HEALTH HISTORY FORM 2019

***Please return by March 1 to*:**
CAMP APOLLO
Post Office Box 34
Plainview, NY 11803

H-1
CAMPER

Completing Grade:_________

TO BE COMPLETED BY PARENT

Name____ **Birth Date**_______________ **Sex**_______ **Age**_____
Last First Initial

Mother/Guardian/Spouse____**Daytime** # (_______)______________________

Cell # (______)____________________ **Home** # (______)___________________ **Work # (**______**)**_________________

Father or Guardian: ____**Daytime** (____)_____________________

Cell # (______)__________________**Home** # (______)___________________ **Work # (**______**)**_________________

Mother's Email ______________________________ ___ Father's Email _______ ____________________________

Address: ____
\# and Street City State Zip

Emergency Contact #1 Name: _______________________________ Emergency Contact # (____)_____________________

Emergency Contact #1 Name: _______________________________ Emergency Contact # (____)_____________________

HEALTH HISTORY (TO BE COMPLETED BY PARENT)

Allergies to food or medication: ____

Special Dietary Needs ____

Epipen Required? YES or NO

Operations or Serious Injuries ____

Chronic or Recurring Illness or Medical Condition ____

Daily Medications? (**IF YES, MUST FILL OUT H-3 FORM**) ____

As Needed Medications? (**IF YES, MUST FILL OUT H-3 or H-4 FORM**)____

H-2

CAMPER

__Please return by March 1 to__:
CAMP APOLLO
Post Office Box 34
Plainview, NY 11803

MEDICAL EXAM FORM 2019

Name:____ **Birth Date:**__________________
Last First

Date of Physical Exam:_________________________

MEDICAL EXAMINATION – An examination for some other purpose within the year is acceptable. It is not necessary to fill this form out if your physician has provided their own physical exam form. The exam must be an updated yearly physical!

TO BE COMPLETED AND SIGNED BY PHYSICIAN

Height:	Eyes:
Weight:	Ears:
Blood Pressure:	Nose & Throat:
Pulse:	Mouth & Teeth:
	Heart:
Urinalysis:	Lungs:
	Abdomen:
	Scoliosis:
ALLERGIES:	

Recommendations and restrictions while in camp:

Dietary Restrictions____

Under Physicians Care for the following conditions: ____

Current Medications (name)________________________________ Is parent sending medicine to camp? ______________

Doctor prescription MUST be included for any medication, including over the counter medications. See forms H-3 and H-4.

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

________________________________M.D. ____________________ Address: ______________________________
Examining Physician Date

____

IMMUNIZATION HISTORY – Please send on a separate sheet. This is to be completed by a licensed physician. This is a record of basic immunizations and most recent booster doses.

***Please return by March 1 to*:**
CAMP APOLLO
Post Office Box 34
Plainview, NY 11803

H-3

REQUEST FOR ADMINISTRATION OF MEDICATION-2019

This form and/or the as needed medication form must be filled out for all medications that are to be administered at camp.

I give permission for my child ________________________________ to receive medication during camp
Camper's name

hours as instructed by my physician.

________________________ ________________ ________________
Signature Relationship Date

TO BE COMPLETED AND SIGNED BY PHYSICIAN

Medication: ______________________ Purpose: ______________________

Dosage: __________________Route: __________ Time of Day: ______________

Special Instructions: ____

Possible Side Effects____

____________________________ ____________________
Signature of Physician Date

TO BE COMPLETED AND SIGNED BY PHYSICIAN

Medication: ______________________ Purpose: ______________________

Dosage: __________________Route: __________ Time of Day: ______________

Special Instructions: ____

Possible Side Effects____

____________________________ ____________________
Signature of Physician Date

H-4

CAMP APOLLO 2019

REQUEST FOR ADMINISTRATION OF AS NEEDED (PRN) MEDICATION DURING CAMP

MEDICATION	DOSING	FREQUENCY	REASON	PHYSICIAN SIGNATURE
Tylenol, Acetaminophen liquid	160mg/5ml, _____ tsp(s)	q _______h prn	HA, fever, pain	
Tylenol, Acetaminophen Jr. tabs	160mg/tab _____ tab(s)	q _______h prn	HA, fever, pain	
Tylenol, Acetaminophen regular strength	325mg/tab _____ tab(s)	q _______h prn	HA, fever, pain	
Tylenol, Acetaminophen Extra strength	500mg/tab _____ tab(s)	q _______h prn	HA, fever, pain	
Advil, Motrin, Ibuprofen liquid	100mg/5ml _____tsp(s)	q _______h prn	HA, fever, pain	
Advil, Motrin, Ibuprofen tabs	200mg/ tab _____tab(s)	q _______h prn	HA, fever, pain	
Benadryl, Diphenhydramine liquid	12.5mg/5ml _____tsp(s)	q _______h prn	Allergic reaction, itching	
Benadryl, Diphenhydramine tabs	25mg/tab _____tab(s)	q _______h prn	Allergic reaction, itching	
Caladryl lotion/spray	Topical	Prn	Itching, bug bites	
Calamine lotion	Topical	Prn	Itching, bug bites	
Neosporin, triple antibiotic ointment	Topical	Prn	Minor cuts	
Dramamine, Dimenhydrinate	50mg/tab ______tab	q _______h prn	Motion sickness	
Sting/itch relief (lidocaine)	Topical	Prn	Bug bites	
Meclizine (Bonine) HCI 25 mg	_______tab(s)	q _______h prn		
TUMS	_______tab(s)	q _______h prn	Upset stomach	

I give permission for my child ________________________________to receive medication during camp hours as
Camper's Name
prescribed by my physician.

______________________________ ____________
Parent signature Date

ALL MEDICATIONS MUST BE SENT IN THE ORIGINAL CONTAINER FROM THE PHARMACY OR DRUGSTORE

7/30/18-gb

2019

Please return by March 1 to:
CAMP APOLLO
Post Office Box 34
Plainview, NY 11803

EPIPEN/AUVI Q PROTOCOL

If your child has an allergy that requires an EPIPEN, we will need a request for administration of medication form (H-3) completed by both the parent and physician, or a written medication authorization (prescription) from your physician.

We will need 2 Epinephrine injectors, along with the corresponding paperwork delivered to camp the week **PRIOR TO THE START OF** camp, so the medical staff has ample time to review and organize all camper's medical paperwork.

BEFORE submitting your 2 Epinephrine injectors and paperwork, please make sure you follow the instructions below.

- PHYSICIANS ORDER FOR THE EPIPEN
- 2 EPIPENS
- CHECK THE EXPIRATION DATE
- CAMPER NAME NEEDS TO BE ON THE BOX/PEN

CAMP APOLLO

2019

__Please return by March 1 to__:
CAMP APOLLO
Post Office Box 34
Plainview, NY 11803

H-6

EMERGENCY CONTACTS/ADDITIONAL PEOPLE WITH PERMISSION TO PICK UP MY CHILD

NAME: ____ **DOB**_______________ **GROUP**________________
Last Name First Name

	First & Last Name	Daytime Phone#	Cell Phone#	Relationship
Mother:				Mom
Father:				Dad
Alternate:				
Alternate:				
Alternate:				
Alternate:				
Alternate:				
Alternate:				