



## IMMUNIZATION RECORD

State Law Requires Exact Dates. We Must Have This Info. In Order To Admit Your Child To Camp.

DATE

- |   |       |
|---|-------|
| 1. DTP Series completed on  | _____ |
| 2. Polio (IPV or OPV) Series completed on                                   | _____ |
| 3. TD (Diphtheria/Tetanus) <b>Must have had<br/>Booster within 10 years</b> | _____ |
| 4. Measles Vaccine*   | _____ |
| 5. Mumps Vaccine*   | _____ |
| 6. Rubella Vaccine*   | _____ |
| *OR Combined as MMR   | _____ |
| 7. Other  | _____ |

## MEDICAL RECORD

Are There Any Abnormalities In The Following Areas?

- | No                      |  | Yes |  | No                     |  | Yes |  |
|-------------------------|--|-----|--|------------------------|--|-----|--|
| 1. Ears, Nose or Throat |  |     |  | 7. Metabolic/Endocrine |  |     |  |
| 2. Respiratory          |  |     |  | 8. Allergies           |  |     |  |
| 3. Cardiovascular       |  |     |  | 9. Neuro-Psychiatric   |  |     |  |
| 4. Hernia               |  |     |  | 10. Eyes (glasses)     |  |     |  |
| 5. Gastrointestinal     |  |     |  | 11. Genito-Urinary     |  |     |  |
| 6. Skin                 |  |     |  | 12. Musculo-Skeletal   |  |     |  |

1. Have You Suffered Any Major Illness, Injury, Or Disability In The Past? Explain.
  
2. Have You Had Any History Of Anxiety Or Other Tension States, Eating Disorders Or Emotional Instability?
  
3. Are You *Currently* Under Treatment For Any Illness, Injury Or Emotional Disturbance? Specify:
  
4. Have You Any Known DRUG, INSECT, FOOD, or ENVIRONMENTAL Allergies? Please Specify.
  
5. Do You Carry An Epi-Pen?                      Yes                      No
  
6. Do You Carry An Inhaler?                      Yes                      No

Name of Dr.: \_\_\_\_\_  
(Print or Type)

Dr.'s Address: \_\_\_\_\_  
\_\_\_\_\_

Phone Number: \_\_\_\_\_

## OPTIONAL WAIVER FORMS

### No Health Insurance Waiver

I do **NOT** have health insurance; therefore, I am signing this waiver taking full responsibility for all medical matters regarding my child.

Signature \_\_\_\_\_

Relationship to child \_\_\_\_\_

I \_\_\_\_\_ (parent or legal guardian) take full responsibility for any expenses related to my child's health, be it hospitalization, medicine, or any other cost related to injury or illness, while my child attends camp at Houghton College.

Furthermore, I do NOT hold Houghton College responsible and/or liable for any and all costs relating to my child's health care for any reason during his/her stay at Houghton College.

My child's name \_\_\_\_\_

Parent signature \_\_\_\_\_

### No Childhood Immunizations

I have not immunized my child due to my specific religious beliefs. Therefore, I am signing this waiver taking full responsibility for all medical matters regarding my child that may result from not having the specified shots.

Signature \_\_\_\_\_

Relationship to child \_\_\_\_\_

Furthermore, I do NOT hold Houghton College responsible and/or liable for any health care needs that may arise due to the absence of specified immunizations during his/her stay at Houghton College.

My child's name \_\_\_\_\_

Parent signature \_\_\_\_\_

**PERMISSION TO PARTICIPATE FORM**  
**MUST BE READ AND COMPLETED PRIOR TO CAMP REGISTRATION**

In consideration of being allowed to participate in the activities and programs of Houghton College and to use its facilities and equipment, I do hereby waive, release and forever discharge Houghton College, its officers, agents, employees, representatives, executors, and all others acting on their behalf from any and all responsibility or liability for injuries or damages resulting from my participation in any activities or my use of equipment in the above mentioned facilities.

It is the desire of Houghton College to provide an atmosphere that is both safe for the campers and secure for their personal belongings. Houghton College provides keys to all dorm rooms for a \$20.00 refundable deposit. Campers are responsible for making sure that their rooms are locked at all times. Campers are not allowed in anyone else's room unless that person is present in the room. Houghton College assumes no responsibility for loss or theft of any personal items. We also reserve the right to inspect or search any room or its contents at our discretion without the permission of its occupants.

I also grant permission for photographs of my child to be used in the promotion of Houghton College, unless otherwise noted.

Camper Name: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

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

**TRAVEL PERMISSION SLIP**

In certain situations, it may be necessary for the Houghton College Camps to transport your child to alternate sites. Although your child will be transported on busses by qualified and experienced bus drivers, travel in motor vehicles on public roads always poses the possibility of risk. By signing this slip you are acknowledging that risk and granting permission to Houghton College Camp Directors to transport your child to one of these alternate locations. Please sign and mail this form to us ahead of time or bring with you to registration.

Camper Name: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

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

## MEDICATION INFORMATION

New York State Health Department has specific regulations that impact those children who will need to take prescription or non-prescription medications while here at camp. If your child is on a prescription medication or you expect that your child might need non-prescription ("over the counter") medications, you will need to fill out the medication administration form and have your child bring it to camp. **The New York State Health Department is now requiring that all campers needing medications have a physician's script or standing orders with all medications, including "over the counter" varieties.**

Medications (prescription and non-prescription drugs) must be in the original container and labeled with the patient's full name, the date the prescription was filled, expiration date, direction for use, precautions (if any), storage requirements (if any), dispensing pharmacy (name and address), and name of physician prescribing medication.

A doctor's standing order/written prescription must come with each prescription medication. The pharmacy script label on the original bottle does not replace the standing order. An individual medication order signed by a physician or other medical provider (physician's assistant, nurse practitioner, dentist, etc.) is required for nurses to administer medications (OTC and Prescriptions). Orders confirm that a medication is current and there has been no change in medication or dosage from that which was originally prescribed (listed on prescription container).

Over the counter drugs (Tylenol, aspirin, etc.) cannot be given to children unless they have a standing order/prescription from a physician (including authorization and instructions for use). Parental permission by itself is not sufficient for a nurse to administer or a camper to self-administer OTC medications. Individual patient non-prescription medications should be labeled with the complete name of the patient and stored in the camp's infirmary.

Individuals that may need emergency medications should carry the medications themselves (epi-pens, inhalers). When necessary, staff may be assigned to carry the medication; however, care must be taken to ensure that the patient and medication remain in close proximity to facilitate immediate administration.

A Medication Administration form for your physician to fill out for prescription and "over the counter" medications is included for your convenience. Please fill it out, have your doctor sign it and have your child bring it with them to registration for our camps. **No medications will be able to be administered without this form.**

### Physician's Written Orders for Prescription Medications

Students Full Name	Drug Name	Route	Dosage	Schedule & Indications	Comments	Physician's Signature

### Physician's Written Orders for Non-Prescription Medications

Students Full Name	Drug Name	Route Please circle Preferred Formulation	Dosage	Schedule & Indications	Camper Health Care Provider Order	Comments	Physician's Signature
	Tylenol	PO (chewable tabs, elixir or tabs)	Per label Instructions by age/weight	Q 4 hr. prn for pain or fever > __F	Yes NO		
	Ibuprofen	PO (chewable tabs, elixir or tabs)	Per label Instructions by age/weight	Q 4 hr. prn for pain or fever > __F	Yes NO		
	Robitussin	PO (syrup)	Per label Instructions by age/weight	Q 4 hr. prn for cough	Yes NO		
	Pepto-Bismol	PO (liquid, or chewable tabs)	Per label Instructions by age/weight	Q 30 min. - 1 hr. prn for diarrhea	Yes NO		
	Benadryl	PO (elixir, chewable tabs, or pills)	Per label Instructions by age/weight	Q 6hr. prn for allergic reaction	Yes NO		
	Other	PO	Per label Instructions by age/weight		Yes NO		