



**SPROUT CREEK FARM**  
34 Lauer Road  
Poughkeepsie, NY 12603  
845.485.8438

**HEALTH FORM**

Student's Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Home Address \_\_\_\_\_

\_\_\_\_\_ Telephone \_\_\_\_\_

Father's name - Business/Address \_\_\_\_\_

\_\_\_\_\_ Telephone \_\_\_\_\_

Mother's name -Business/Address \_\_\_\_\_

\_\_\_\_\_ Telephone \_\_\_\_\_

Cell phone number(s): \_\_\_\_\_

In case of emergency, if parents cannot be reached, call \_\_\_\_\_

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

E-Mail Address (Please Print) \_\_\_\_\_

Health Insurance Carrier \_\_\_\_\_ Policy Number \_\_\_\_\_

**GENERAL HEALTH INFORMATION**

1. Has your child had any serious illness, injury, or surgery in the past year? Yes No

If yes, explain. \_\_\_\_\_

2. Has your child had his/her appendix removed? Yes No 3. Does your child have allergies? Yes No

Please specify allergy and reaction: \_\_\_\_\_

Does your child have any special dietary needs? Please specify. \_\_\_\_\_

5. Does your child have any chronic mild illness (i.e. nervous stomach) or physical idiosyncrasy that we should know about? Yes \_\_\_\_\_ No \_\_\_\_\_ Please specify.

**There are four pages to this Health Form.**

**IMMUNIZATION RECORD**

**(The New York State Health Department requires that dates be given or that medical records showing immunization dates be attached.)**

DPT                    \_\_\_\_\_                    \_\_\_\_\_                    \_\_\_\_\_                    \_\_\_\_\_  
MMR                    \_\_\_\_\_                    \_\_\_\_\_                    \_\_\_\_\_                    \_\_\_\_\_  
OPV (Polio)        \_\_\_\_\_                    \_\_\_\_\_                    \_\_\_\_\_                    \_\_\_\_\_  
Hep B                    \_\_\_\_\_                    \_\_\_\_\_                    \_\_\_\_\_                    \_\_\_\_\_  
Name of child's doctor

\_\_\_\_\_  
Telephone

**PARENT'S WAIVER FOR EMERGENCY TREATMENT**

In case of emergency, if parents are not available, I hereby authorize the Director of Sprout Creek Farm or her designee to have my child \_\_\_\_\_ treated by a physician and/or admitted to the emergency room of a hospital.

Parent Signature \_\_\_\_\_

**This waiver shall apply June 1, 2010 through May 31, 2011.**

**Please note: According to New York State Law, the camp nurse MAY NOT administer ANY non-prescription-over-the-counter medicine without the child's physician's signature. While this has been true for prescription medicine, it is now a requirement for non-prescription medicine as well. All Overnight campers must have this form signed and returned whether or NOT parents want non-prescription drugs administered.**

**Please be sure a Doctor signs page four of this form**

INDIVIDUAL ORDERS for NAME \_\_\_\_\_

DOB \_\_\_\_\_ WEIGHT \_\_\_\_\_

The following order form must be completed and signed by the child's physician. If the child will be taking any prescription medications while at camp, the doctor must also complete the reverse side of this form. The camp nurse is only permitted to dispense medications to a child that is listed on this form by the child's doctor.

**Standard and Over the Counter/PRN Medications** The following medications are available in the Infirmary and will be administered at the discretion of an RN, IF approved by the camper's healthcare provider.

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 tables)	Per label Instructions by age/weight	Pain or fever	Ye 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 or tab)	Per label Instructions by age/weight	Diarrhea	Yes No	
Children's Mylanta (or generic)	PO 9chewable tab)	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	
Dramamine/Bonine (or generic)	PO (chewable/regular tabs)	Per label Instructions by age/weight	Motion sickness	Yes No	
Dimetapp (or generic)	PO (elixir or tabs)	Per label Instructions by age/weight	Nasal congestion, Seasonal allergy	Yes No	
Benadryl (or generic)	PO Elixir, chewable, tab or pills)Topical (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 Instruction	Allergic reactions, contact dermatitis, insect bite)	Yes No	
Calamine Lotion (or generic)	Topical	Per label Instruction	Allergic reaction (hives, insect bite)	Yes No	

**Required :**

**Doctor's**

**Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

**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 health care provider to be implemented by an RN.

Doctor's Name \_\_\_\_\_ Phone # \_\_\_\_\_

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

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

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**Revised: January 2010**