BCAP

brooklyn cultural adventures program

MEDICAL FORM – 2012 SEASON

A separate form is required for each child at camp.

Camper Name: ______________________________, ______________________________

(Last) (First)

Birth Date: ______/______/________ **Gender (F/M):** ________

Home Phone: ________ - ________ - __________

Custodial Parents

	Parent/Guardian 1	Parent/Guardian 2
Full Name		
Relationship to Camper		
Primary Daytime Phone		
Secondary Daytime Phone		

Emergency Information

In case of emergency, parents/guardians are contacted first by default. Emergency contacts are contacted if we are unable to contact either parent/guardian. Please provide us with the contact information for two emergency contacts and indicate if you would like either of these contacts to be the first person we contact in case of emergency.

	Parent/Guardian 1	Parent/Guardian 2
Full Name		
Relationship to Camper		
Primary Daytime Phone		
Secondary Daytime Phone		
Contact this person first in case of emergency.		

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Camper Name: ______________________________, ______________________________

(Last) (First)

Family Health Care Providers

	Name	Phone
Primary Physician/Pediatrician		
Dentist		
Orthodontist (if applicable)		
Mental Health Provider		

Health Insurance

Insurance Group: ______________________________

Insurance Group Address: ______________________________

City ______________________ State: __________ Zip: ______________

Policy Number: ______________________________

Group Number: ______________________________

Name of Insured: ______________________________

Relationship to Camper: ______________________________

Policy Holder's Insurance ID Number or Social Security: ______________________________

Prescription Plan: ______________________________

Prescription Plan Number: ______________________________

Camper Name: ______________________________, ______________________________

(Last) (First)

Health History

History of Illness

Indicate the following by entering an approximate date of last occurrence. Leave blank if not applicable.

Disease	Date	Disease	Date
Chicken Pox:	__________	Hepatitis A:	__________
Measles:	__________	Hepatitis B:	__________
German Measles:	__________	Hepatitis C:	__________
Mumps:	__________		_

List and describe any chronic or recurring illnesses that your child may have. If your child has no chronic or recurring illnesses, please answer N/A

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Asthma

Has your child every displayed asthma symptoms? ☐ Yes ☐ No ☐ I'm not certain

If yes, provide the approximate date for the last time your child suffered from asthma symptoms

_______/________/_______________

Has your child ever been prescribed treatment for asthma (such as a pump)? ☐ Yes ☐ No

Does Your child presently use any form of asthma treatment? ☐ Yes ☐ No

Camper Name: ______________________________, ______________________________
(Last) (First)

General Health Symptoms and Conditions Survey. Please check any that apply and explain in the space at the bottom of the page. If none of these symptoms apply to your child, please mark *None of the above*.

- ☐ Frequent headaches
- ☐ Head injury
- ☐ Skin problems (itching, rash)
- ☐ Frequent ear infections
- ☐ Eating disorder
- ☐ Problem with joints (ankles, knees)
- ☐ Back problems
- ☐ Bed wetting
- ☐ Sleep walking
- ☐ Diarrhea/Constipation
- ☐ Diabetes
- ☐ High blood pressure
- ☐ Seizures/Convulsions
- ☐ Heart murmur
- ☐ Acne
- ☐ Bleeding/Clotting
- ☐ Knocked unconscious
- ☐ Mononucleosis (past 12 months)
- ☐ Orthodontic appliance required
- ☐ Abnormal menstrual history
- ☐ Emotional problems referred to treatment at camp
- ☐ Glasses, contacts, protective eyewear required at camp
- ☐ None of the above

Reactions to Physical Excercise

- ☐ Passed out
- ☐ Dizziness
- ☐ Chest pain
- ☐ Difficulty breathing
- ☐ None of the above

Comments:

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Camper Name: ______________________________, ______________________________

(Last) (First)

Physical Conditions

Serious Injuries (with Dates) Please list and describe any serious injuries your child has had. Please provide the approximate dates for each injury. If your child has never been serious injured, answer N/A.

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Surgeries and Major Medical Procedures (with Dates) Please list and describe any surgeries or other major medical procedures performed on your child. Please provide the approximate dates for each injury surgery or other major medical procedure. If your child has never undergone, any surgeries or other major medical procedures answer N/A.

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Special Physical Needs Please list and describe any other special physical needs your child may have. Include any special accommodations your child may require. If this does not apply to your child, please answer N/A.

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Camper Name: ______________________________, ______________________________

(Last) (First

Environmental Allergies (Non-Dietary)

☐ Pollen/Hay Fever ☐ Grass ☐ Dust ☐ Sun

☐ Bee Stings ☐ Other Insect Stings ☐ Animal fur/Dander

☐ Contact with wheat (without being eaten)

☐ Contact with peanut oil (without being eaten)

☐ Other (Specify) ____

☐ None of the above

Dietary Allergies

☐ Peanuts ☐ Shell fish ☐ Citrus ☐ Berries

☐ Wheat ☐ Tree nuts ☐ Whey ☐ Mustard ☐ Flat fish

☐ Other (Specify) ____

☐ None of the above

Penicillin Allergy Is your child allergic to penicillin?

☐ Yes ☐ No ☐ I'm not sure

EpiPen Do you have a prescription for an EpiPen for your child?

☐ Yes ☐ No

Comments and Special Instructions Include description of critical allergic reactions.

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Camper Name: ______________________________, ______________________________

Dietary Preferences

☐ Vegetarian ☐ Vegan ☐ No Dairy ☐ No Pork ☐ No Poultry

☐ Kosher ☐ Halal ☐ No Red Meat ☐ No Seafood ☐ No Eggs

☐ Other: ____

☐ None of the above

Mental/Emotional Health

Please check any that apply and explain below:

☐ Diagnosis of Attention Deficit Disorder (ADD or AD/HD)

☐ Diagnosis of Asperger's Syndrome

☐ Diagnosis of depression, OCD, panic/anxiety disorder

☐ Significant learning or processing challenge (disability)

☐ Currently seen by professional for mental/emotional health concerns

☐ Treated with medications for mental/emotional problem

☐ Other emotional health concern)

Comments: ____

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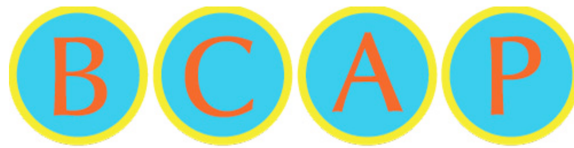
If any of the above are checked, please have the mental health professional send a written statement to the camp, describing:

a) The condition and treatment plan, including any medications
b) Any behavior that this child may engage in at camp that may require special accommodation by camp staff and a description such accommodations
c) Any behavior that this child may engage in at camp that may require intervention by a mental heath care professional
d) A recommendation for participation in our camp program

If medication for any of the above has been prescribed, also provide:

e) Certification that the applicant has been taking the same medication at the same dose for 3 months prior to the start of camp
f) If (d) is not true, a detailed explanation for the change in medication.



Camper Name: ______________________________, ____________________________

Medications

Send enough medication to last while your child is at camp! Keep it in the original packaging. If a prescription, the label should include the drug, dosage, time(s) of delivery and physician's name. Please provide an original order from the prescribing physician for any medications that your child may need to take while at camp**. No medication will be administered by BCAP staff members. BCAP will only observe children who self-administer required medications**

If the applicant is to take medications routinely at camp, including over-the-counter or other non-prescription drugs, please enter these medications below.

Medication (or common name)	**Dosage**	**Delivery**
1. ________________________	__________	☐ Breakfast ☐ Lunch ☐ Dinner
Physician: ______________________________		☐ Taken regularly ☐ As needed
Physician's Phone: ______-_______-_________		☐ While at camp ☐ Until ___ / ___
2. ________________________	__________	☐ Breakfast ☐ Lunch ☐ Dinner
Physician: ______________________________		☐ Taken regularly ☐ As needed
Physician's Phone: ______-_______-_________		☐ While at camp ☐ Until ___ / ___
3. ________________________	__________	☐ Breakfast ☐ Lunch ☐ Dinner
Physician: ______________________________		☐ Taken regularly ☐ As needed
Physician's Phone______-_______-_________		☐ While at camp ☐ Until ___ / ___
4. ________________________	__________	☐ Breakfast ☐ Lunch ☐ Dinner
Physician: ______________________________		☐ Taken regularly ☐ As needed
Physician's Phone: ______-_______-_________		☐ While at camp ☐ Until ___ / ___

Special Medication Instructions:

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