Registrar Office:
6 Soundview Drive North
Huntington, NY 11743
(631) 351-1657

Website: www.mahetu.org
Email: info@mahetu.org

ACA Accredited

Form 2: Camper Health Recommendations

(To be completed by Licensed Medical Professional)

Camper Name: _____ (Last Name) _____ (First Name) _____ (Middle Initial)

Date of Birth: _____ (MM/DD/YY)

NYS Dept of Health requires a complete physical exam within 12months of attending camp

Date of Last Physical Exam: _____ (MM/DD/YY)

Weight: _____ lbs

Height ____ ft ____ in

HR: _____ bpm

BP: _____/_____

Allergies: (Please Specify)

☐ Food:
☐ Medications:
☐ Environment:
☐ Other:

Describe Previous Reactions. Risk of Anaphylaxis? (Submit Emergency Action Plan, if applicable)

Does this camper require an EpiPen? ☐ Yes ☐ No

If Yes
☐ EpiPen (0.3mg/0.3ml) IM
☐ EpiPen Jr (0.15mg/0.15ml) IM

Diet/Nutrition:

☐ No Diet Restrictions ☐ Vegan ☐ Lactose Intolerant
☐ Vegetarian ☐ Gluten Free ☐ Other (Specify):

The camper is undergoing treatment at this time for the following conditions: (describe below)

☐ None

Other treatments/therapies to be continued at camp: (describe below)

☐ None Needed

Camper Health Form 2
(To be completed by Licensed Medical Professional)

Camper Name: _____ Date of Birth: _____
(Last Name) (First Name) (Middle Initial) (MM/DD/YY)

Restrictions:
Do you feel that the camper will require limitations or restrictions to activity while at camp?
☐ No ☐Yes
If you answered yes to this question, what do you recommend? (describe below or include attachment)

Immunization History: Attach copy of immunization forms from Health Care provider or State/Local government.

Immunization	Dose 1 Month/Yr	Dose 2 Month/Yr	Dose 3 Month/Yr	Dose 4 Month/Yr	Dose 5 Month/Yr	Most Recent Dose Month/Yr
Diptheria, tetanus, pertussis (DTaP)/(TdaP)						
Tetanus Booster (dT) or (TdaP)						
Mumps, Measles, Rubella (MMR)						
Polio (IPV)						
Haemophilus influenzae type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella						
Meningococcal meningitis (MCV4)						

Tuberculosis (TB) Test Date: _____ Result: ☐ Negative ☐Positive ☐N/A

Camper Health Form 2
(To be completed by Licensed Medical Professional)

Camper Name: _____ Date of Birth: _____
(Last Name) (First Name) (Middle Initial) (MM/DD/YY)

Individualized Standing Orders (Non-Prescription Medications):

The following non-prescription medications are available in the Camp Health Center. New York State Law requires approval by a Licensed Health Care Professional (MD, DO, NP or PA) for these medications to be dispensed to the camper when indicated.

Drug Name	Route	Dosage & Schedule	Schedule & Indications	Healthcare Provider Order & Initial		Comments
Acetaminophen (Tylenol)	PO	Per label instructions	Pain or Fever	☐ Yes	☐ No	
Ibuprofen (Motrin/Advil)	PO	Per label instructions	Pain or Fever	☐ Yes	☐ No	
Decongestant/cough suppressant (Dayquil/Robitussion)	PO	Per label instructions	Cough	☐ Yes	☐ No	
Throat lozenges and/or Chloroseptic spray	PO	Per label instructions	Sore throat	☐ Yes	☐ No	
Laxatives (Milk of Magnesia/Miralax)	PO	Per label instructions	Constipation	☐ Yes	☐ No	
Bismuth (Children's Pepto Bismol)	PO	Per label instructions	Indigestion, Nausea, Emesis	☐ Yes	☐ No	
Antacid: (Maalox/Tums/Mylanta)	PO	Per label instructions	Abdominal Upset	☐ Yes	☐ No	
Ear drying aid (Swimmers ear)	topical	Per label instructions	Suspicion of Swimmer's ear	☐ Yes	☐ No	
Antihistamine (Diphenhydramine/ Cetiriine/Fexofenadine/ Loratidine)	PO	Per label instructions	Allergic reaction (itching, rash, hives) Seasonal Allergy symptoms	☐ Yes	☐ No	
1% Hydrocortisone	topical	Per label instructions	Bee stings, insect bites, Poison Ivy, Poison Oak, Poison Sumac	☐ Yes	☐ No	
Diphenhydramine cream/ointment	topical	Per label instructions	Bee stings, insect bites, Poison Ivy, Poison Oak, Poison Sumac	☐ Yes	☐ No	
Calamine lotion or generic	topical	Per label instructions	Insect bites, Poison Ivy, Poison Oak, Poison Sumac	☐ Yes	☐ No	
Over-the-Counter Pediculocide	topical	Per label instructions	Head lice	☐ Yes	☐ No	
Analgesic balm (Mineral Ice/Icy-Hot)	topical	Per label instructions	Muscle aches and backaches	☐ Yes	☐ No	
Hydrogen Peroxide	topical	Per label instructions	Wound cleansing	☐ Yes	☐ No	
0.9 % Sodium chloride	topical	Per label instructions	Wound cleansing, Eye irritation, soak	☐ Yes	☐ No	
Povidone Iodine swab	topical	Pre-packaged	Wound disinfectant	☐ Yes	☐ No	
Antibacterial Ointment (Bacitracin/Triple Antibiotic)	topical	Per label instructions	Abrasions, cuts, scratches and infections	☐ Yes	☐ No	

Camper Health Form 2
(To be completed by Licensed Medical Professional)

Camper Name: ______________________________ Date of Birth: __________
(Last Name) (First Name) (Middle Initial) (MM/DD/YY)

Camper Medications to be taken at camp: (to be filled by Health Care Provider)
Please list all medications the camper will require to take at camp. This includes over-the-counter or non-prescription medications taken routinely or as needed (PRN). Parents must send medication in un-opened original packaging. Medications in unlabeled bottles or pill-boxes will not be accepted. All medications must be submitted to Camp Health Center, and cannot be kept with the camper.

Medication: ☐ This camper will not take any daily medications while attending camp.
☐ This camper will take the following daily medication(s) while at camp.

Prescription/Non Prescription Medication	Route	Dosage	Schedule	Indications
			☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐As Needed ☐Other:	
			☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐As Needed ☐Other:	
			☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐As Needed ☐Other:	
			☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐As Needed ☐Other:	
			☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐As Needed ☐Other:	

I have reviewed the camper's health history and have discussed the camp program with the camper's parent/guardian. It is my opinion that the camper is physically and emotionally fit to participate in an active camp program (except as noted above on page 2 above).

Name of Licensed provider (print)______________________ Signature__________________
Office Address ______________________________License # ________________
Telephone ______________________________ Date______________________________