

COOPERSTOWN DREAMS PARK
Camper Information: *(to be filled out by parent)*

2023

Date Attending (from/to)

Team Name:

Last Name: First Name: Gender: DOB:

Address:

Parent/Guardian: Phone# Home Work Cell

If parent / guardian is coming to Cooperstown, address where they are staying

Health History and Immunization Records

A photocopy of complete immunization records MUST be attached

Yes / No If your child is covered by health insurance please attach a photocopy of your camper's insurance card

Allergies(please list)

Asthma Mild Moderate Severe Exercise Induced

Diabetes

Seizure Disorder

Heart Disease (please explain)

Other (please explain)

**All medications sent to camp must be in their original containers, including inhalers, which must come in their prescription labeled box
** No pill boxes or unlabeled containers will be accepted ****

- IMPORTANT - THIS CONSENT MUST BE COMPLETED FOR ATTENDANCE -

This health history is correct to the best of my knowledge, and the person herein described has permission to engage in all camp activities except as specifically noted. In the event of serious illness or injury, I hereby give Cooperstown Camp Services permission to provide emergency treatment and referral to a hospital in the event I cannot be reached. I give permission to the physician selected by the camp Health Director to hospitalize, secure proper treatment for, and to provide anesthesia, pain control, and/or other invasive treatments in the event of severe illness or injury to my child as named above. I also give permission for my child's personal, protected medical information provided on this form, and any personal protected health information collected by personnel of Cooperstown Camp Services to be released to any hospital and/or clinic providing treatment, Cooperstown Dreams Park management, and any insurance company representing Cooperstown Dreams Park.
This form may be photocopied for use outside of camp.

Required - PARENTAL AUTHORIZATION AND CONSENT – Required

Signature: Date:

I, *(the above indicated)* hereby authorize and entrust the below list of coaches and other persons to act in my place, to exercise full parental authority (including medical care authorization) and control over my child while at Cooperstown Dreams Park.

- | | |
|-------------------------|-------------------------|
| 1. <input type="text"/> | 5. <input type="text"/> |
| 2. <input type="text"/> | 6. <input type="text"/> |
| 3. <input type="text"/> | 7. <input type="text"/> |
| 4. <input type="text"/> | 8. <input type="text"/> |

COOPERSTOWN DREAMS PARK

Camper Examination and Medications

This form is to be completed by a Physician, Physician Assistant, or Nurse Practitioner

Doctor Examination or School Physical **Must Be COMPLETED within 12 months from the start of camp **

Last Name: First Name:
Team Name: Date Attending (from/to)

Medications Listed Here:

Dosing will be per label instructions by Age/Weight as needed

New York State Department of Health requires that camps have an individualized set of standing orders for each camper attending. This list is for standard "Over the Counter" medications that campers may require while at camp. *These medications are available at the camp infirmary.* The medications will only be administered at the discretion of a Registered Professional Nurse.

A licensed health care provider needs to check the YES box if they wish the child to be eligible to receive the medication indicated.

Yes No	Yes No	Yes No	Yes No
<input type="checkbox"/> <input type="checkbox"/> Acetaminophen (Tylenol)	<input type="checkbox"/> <input type="checkbox"/> Antibiotic Cream	<input type="checkbox"/> <input type="checkbox"/> Mylanta	<input type="checkbox"/> <input type="checkbox"/> Hydrocortisone 1% Cream
<input type="checkbox"/> <input type="checkbox"/> Ibuprofen (Advil)	<input type="checkbox"/> <input type="checkbox"/> Calamine Lotion	<input type="checkbox"/> <input type="checkbox"/> Zyrtec	<input type="checkbox"/> <input type="checkbox"/> Claritin
<input type="checkbox"/> <input type="checkbox"/> Diphenhydramine (Benadryl)	<input type="checkbox"/> <input type="checkbox"/> Antacids (Tums)	<input type="checkbox"/> <input type="checkbox"/> Dextromethorphan (cough syrup)	<input type="checkbox"/> <input type="checkbox"/> Other <input type="text"/>

All medications sent to camp must be in their original containers, including inhalers, which must come in their prescription labeled box

** No pill boxes, or unlabeled containers will be accepted **

Below, please list any Prescribed, or "Over-the-Counter" medications (not listed above), that the child will provide and take **WHILE AT CAMP**

Drug Name	Dosage	Route	Schedule / Indication	Comments
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

The camper is under the care of a physician for the following conditions:

Physician ordered treatments to be continued at camp:

Health Care Provider:

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

Name: Phone:
Address: License #:
Provider Signature and Practice Stamp: Exam Date:

Camper exam **Must Be COMPLETED** within 12 months from the start of camp