



### MEDICAL FORM (To be completed by Physician)

Student Name: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth (MM/DD/YYYY): \_\_\_\_\_ M / F (Please circle one)

#### MEDICAL HISTORY

Please indicate the childhood illnesses the student has had and complete the information about the student's current physical condition. If the student has not had that illness or disease, please check the "NO" box.

CHILDHOOD ILLNESSES	Yes	No	Date	CURRENT PHYSICAL CONDITIONS	Yes	No
Chicken Pox				Asthma		
German Measles				Bleeding/Clotting Disorder		
Measles				Cancer		
Mumps				Convulsions/Seizures		
				Diabetes		
				Frequent Ear Infections		
<b>ALLERGIES</b>				Heart Defect/Disease		
Hay Fever				High Blood Pressure		
Insect Sting Reaction				Kidney Disease		
Penicillin				Lung Disease		
Poison Ivy, Poison Oak, etc.				Vision Impairment		

Does the student have any food/medication/other allergies? If so, please list.

#### IMMUNIZATION HISTORY

The New York State Department of Health requires a complete immunization history for each student enrolled in HCCEP. This information must be completed by the student's physician or nurse practitioner. We also ask that the HCCE Program Coordinator be notified if the student has been exposed to any communicable diseases in the three weeks prior to the start of the program.

**The student cannot be enrolled until we have this information on file.**

<b>DTaP</b> (Diphtheria, Tetanus & Pertussis) List dates received	1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>	4 <sup>th</sup>	5 <sup>th</sup>
<b>HIB</b> (Hemophilus Influenza Type B) List dates received	1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>	4 <sup>th</sup>	Booster
<b>HB</b> (Hepatitis B) List dates received	1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>	4 <sup>th</sup>	
<b>Polio</b> (Inactivated oral) List dates received	1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>	4 <sup>th</sup>	
<b>MMR</b> (Measles, Mumps, Rubella) List dates received	1 <sup>st</sup>	2 <sup>nd</sup>			
<b>Varicella</b> (chicken pox) List dates received	1 <sup>st</sup>	2 <sup>nd</sup>			
<b>Tdap</b> (Tetanus, diphtheria, & pertussis) List dates received	1 <sup>st</sup>	Booster	<b>TB Mantoux</b> (Tuberculin skin test) Test given?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date: _____

I verify that all immunizations are current for the above named student.

Name of Doctor or Nurse Practitioner \_\_\_\_\_

Doctor's Address \_\_\_\_\_

Doctor's Phone Number \_\_\_\_\_  
**(REQUIRED)**

Doctor's Signature \_\_\_\_\_  
**(REQUIRED)**

Date \_\_\_\_\_

**6-DAY MEDICATION RECORD**

○ July 23 – 28, 2022

Name \_\_\_\_\_

Date of Birth \_\_\_\_\_  
(MM/DD/YYYY)

**IT IS HCCEP PROGRAM POLICY THAT, AT CHECK IN, ALL MEDICATIONS MUST BE GIVEN TO HCCEP HEALTH STAFF TO BE KEPT IN A SECURE PLACE MONITORED BY EYF HEALTH STAFF OR TEAM LEADERS.**

MEDICATION NAME	MEDICAL CONDITION	DOSE	START DATE	END DATE	TIME (am/pm) or with Meal

\*\* If you need more space, please attach additional page. This form is confidential and will be shredded by August 15, 2022. \*\*

**All medications must be in their original vial, and must be accompanied by a patient-specific written order from a licensed prescriber. Pharmacy labeling is NOT sufficient.**

Medications will not be accepted if they are in pill boxes, Ziploc baggies, etc.

**OVER-THE-COUNTER MEDICATIONS ARE NOT AVAILABLE AT HCCEP.**

**Any over-the-counter medications must be prescribed by a doctor with the camper’s full name, date of birth and a valid expiration date not to expire before the start of the program and in the original container. Examples of over-the-counter medications include, but are not limited to, Tylenol, Advil, Benadryl, Midol and Tums.**

I give permission for the camp medical director to administer medication as dictated by prescription.

Parent/Guardian name (please print) \_\_\_\_\_

Parent/Guardian signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor’s signature \_\_\_\_\_ Date \_\_\_\_\_  
**(REQUIRED)**