

Medical Form Instructions:

This form is REQUIRED for each camper. **It needs signatures from both the Parent AND the Health Care Provider.**

Please complete this form and mail it (with any other necessary forms like the Check Payment and Discount Forms) to the Camp Registrar at:

Camp Registrar
279 River Street
Rochester, NY 14612

Most questions can be answered on the camp website FAQ section at <http://www.liloli.org/>.

For further questions or information, you can contact our volunteer registrar at: registrar@liloli.org or call the camp information line at 1-877-518-1704 from 9am to 9pm.

Note that some of the medical information can be recorded online if you desire. Each year you can verify the information is correct instead of re-entering the same information each year.

Please verify that any previously entered medical information is still current and applicable for this year at camp.

Note that all of this information must be completed for each camper; though some of it can be online if you wish.

Here is a table to help understand your options:

	Online	/	Paper Form
Insurance information	Yes	or	Yes
Immunization information	Yes	or	Yes
Health history, allergies, hospitalizations	Yes	or	Yes
Standing orders	No		Yes
Prescription medications	No		Yes
Health care provider's signature	No		Yes
Release form	No		Yes
Parent or guardian's signature	No		Yes

MEDICAL INFORMATION FORM

for (camper's name) _____

STANDING ORDERS: The following standard over the counter medications are available in the Camp Li-Lo-Li infirmary and will be administered as per direction given below by the Health Care Provider (HCP). Without this signature, the camper cannot be given any of these medications under New York State Law.

Drug Name	HCP's Approval
Acetaminophen (i.e.Tylenol)	<input type="checkbox"/> YES <input type="checkbox"/> NO
Ibuprofen (i.e.Advil/Motrin)	<input type="checkbox"/> YES <input type="checkbox"/> NO
Naproxen (i.e.Aleve)	<input type="checkbox"/> YES <input type="checkbox"/> NO
Benadryl- liquid or capsules	<input type="checkbox"/> YES <input type="checkbox"/> NO
Robitussin DM (Cough Syrup)	<input type="checkbox"/> YES <input type="checkbox"/> NO
Dimetapp (Cough & Cold elixir)	<input type="checkbox"/> YES <input type="checkbox"/> NO
Sudafed tablets (Decongestant)	<input type="checkbox"/> YES <input type="checkbox"/> NO
Immodium tablets (Anti-diarrheal)	<input type="checkbox"/> YES <input type="checkbox"/> NO
Polysporin eye/ear drops	<input type="checkbox"/> YES <input type="checkbox"/> NO
Tums (Antacid tablets)	<input type="checkbox"/> YES <input type="checkbox"/> NO
Antiseptic throat spray	<input type="checkbox"/> YES <input type="checkbox"/> NO
Calamine/Caladryl lotion	<input type="checkbox"/> YES <input type="checkbox"/> NO
Triple antibiotic ointment	<input type="checkbox"/> YES <input type="checkbox"/> NO
Silvadene burn cream	<input type="checkbox"/> YES <input type="checkbox"/> NO
Claritin tablets (Allergies)	<input type="checkbox"/> YES <input type="checkbox"/> NO
This child is able to swallow pills:	<input type="checkbox"/> YES <input type="checkbox"/> NO

Prescription Medications	Route	Dosage	Schedule & indications	Comments

Current medications **MUST** be brought in **original container** with instructions!

Health Care Provider's Name	
Address	Phone: ()
License #	Date
HCP Signature	

Items marked with this icon can be left blank here and completed online. Please verify that that last year's online information is still correct for this year.

INSURANCE:

Company: _____

ID# _____

Group# _____

Policy# _____

Certificate# _____

- Submit copy of insurance card if possible
- Canadian campers must bring their health care card to camp and leave it there during their session

HOSPITALIZATION OR SURGERY WITHIN THE LAST YEAR : _____

ALLERGIES: (explain reaction as well) **Carries EpiPen**

_____ Bees or Insect Bites/Stings

_____ Penicillin

_____ Foods (Specify) : _____

_____ Other (Specify) : _____

HEALTH HISTORY: (Check if any apply & explain, using separate paper if necessary)

_____ Asthma

_____ Diabetes

_____ Seizures &/or Epilepsy

_____ Frequent Ear Infections

_____ Bedwetting

_____ Bleeding/Clotting Disorder

_____ Emotional/Behavioral Disorder

_____ Heart defect/ disorder

_____ Other: please specify: _____

INCLUDE COPY OF IMMUNIZATION RECORD (dates are required by law for minors)

RELEASE TO BE SIGNED BY PARENT/GUARDIAN OF A MINOR:

- I hereby grant permission to the camp medical personnel to administer any necessary medical treatment to my child while at camp, including but not limited to, first aid and administering over the counter medication according to standing orders from the camper's health care provider.
- In the event of an emergency where I cannot be reached, I hereby give permission to the physician selected by the camp to take whatever action is necessary to care for my child, including but not limited to, ordering x-rays and appropriate tests, hospitalization, injections, anesthesia and or surgery for my child as named above.
- I hereby grant permission for camp medical personnel to obtain access to necessary medical, psychiatric or social work records and to receive the results of medical procedures completed while my child is enrolled at camp. I also grant the release of any records necessary for treatment, referral, billing or insurance purposes.
- I understand that if my child requires medical treatment off camp property, I am responsible for any expenses, including but not limited to, co-payments as required by and associated with this treatment according to the guidelines of my own insurance coverage.
- I give permission to the camp medical staff to administer the over OTC and prescription medications indicated as ordered by my child's health care provider.
- I understand that if the Standing Orders chart at left is NOT signed by my child's health care provider, my child will NOT be given any over the counter medications at camp.
- Camp Li-Lo-Li may use photos or videos taken at camp for promotional purposes
- I give permission for my child to participate in all camp activities including :

Ropes Course and Climbing Tower

☐ YES ☐ NO

Out of camp canoe trips

☐ YES ☐ NO

SIGNATURE(Parent/Guardian) _____

Name (please PRINT) _____ Date ____/____/____

Required by New York State Health Department: Information regarding the **MENINGOCOCCAL MENINGITIS IMMUNIZATION** (Menactra™) will be sent to all campers who plan to stay for **more than 7 consecutive nights**. Response from parent/guardian will be required