CAMP HUNT
WHERE FRIENDSHIPS BEGIN

2018

Authorization & Release Form
Mail to: Camp Hunt Admissions
PO Box 2358, Liverpool, NY 13089

Camper Information

Last Name: _____ First Name: _____ Home Phone: _____ M / F Sex _____ DOB: _____

Health Insurance Provider: _____ Policy Number: _____ Home Congregation: _____

Sessions Attending: Senior _____ General A _____ General B _____ Intermediate _____ Junior _____

T-Shirt Size (circle one) : Adult - S, M, L, XL, 2XL Youth - S, M, L

Family Information

Parent Last Name _____ First Name _____ Parent Home Phone _____ Parent Work / Cell _____

Address: _____ City: _____ ST _____ Zip _____

Immunization Record

_____ _____ _____ Hepatitis B (Hep B) – 3 Doses

_____ _____ Measles, Mumps, Rubella (MMR – 2 Doses)

_____ _____ _____ _____ _____ Diphtheria, Tetanus, Pertussis (DTaP or DTP) – 5 Doses

_____ _____ _____ _____ H. Influenza type B (HiB) – 4 Doses

_____ Tetanus – Diphtheria (Td) Latest Immunization Only

_____ _____ _____ _____ Polo Vaccine – 4 Doses

_____ _____ Varicella (Chickenpox) – 2 Doses

** Note: Immunization records from previous years are on file. If, however, the child has received any immunization in the last year, please note it.

You do not have to fill in blanks if you attach immunization records.

Medical Conditions and History

_____ Height _____ Weight _____ Medical Disabilities and Restrictions

_____ Chicken Pox _____ Rubella _____ Heart Disease

_____ Measles _____ Rheumatic Fever _____ Asthma

_____ Mumps _____ Convulsions _____ Ear Problems

Behavioral Problems (Please Explain)

Please describe on a separate page any allergies or special condition, any activities to encourage or discourage, and any medications (prescription or over the counter) your child will be taking while at Camp. PLEASE NOTE: No medication (prescription or over the counter) may be administered at Camp Hunt without a written Physician's Order, or a properly labeled, unaltered prescription bottle. All medication must be in an original (over the counter or prescription) container.

Authorization for Medical Treatment of Minors:

I / We _____, the parent(s) or legal guardian(s) of _____ ,

DOB _____ , Do hereby appoint the Camp Hunt nurse and / or authorized staff of CAMP HUNT, Hubbardsville, New York, (315) 824-1827, to act in my / our behalf in authorizing unexpected medical, dental, surgical, and hospital care for the above named minor during the period my / our absence from 6/1 to 8/31. This Document may be presented to a physician, dentist, or appropriate hospital representative at such time as unexpected medical, dental, surgical, or hospital care may be required.

Signed: _____ Witnessed: _____

Date Signed: _____ Date Witnessed: _____

Family Physician: _____ Physician's Phone: _____

Meningitis Immunization Response

New York State Public Health Law requires the operator of an overnight children's camp to maintain a completed response form for every camper who attends camp for seven (7) or more nights.

Please check one box and sign below.

☐ My child has received the meningococcal meningitis immunization (Menomune ™, Menactra™) within the past ten (10) years.
Date received: _____
[Note: The vaccine's protection may last for only 3-5 years. Consult your physician for revaccination recommendations.]

☐ I have read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that my child will not obtain immunization against meningococcal meningitis disease.

Signed: _____ Date: _____
(Parent / Guardian)

Alternate / Emergency Contact In Case Parent / Guardian Cannot Be Reached:

Name: _____ Relationship: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Photo Release:

I / We _____, the parent(s) or legal guardian(s) of _____ ,

DOB _____ , Do hereby permit Camp Hunt to use Photographs of my child in its advertising and promotional efforts [such as Camp Hunt's facebook, newsletters, website, and end of the week power point presentation for campers and staff] .

Signed: _____ Date: _____
(Parent / Guardian)

Parent / Guardian MUST Sign:

This application has my approval. I agree that camping fees will be paid in advance for each period and will not be refunded if this child leaves CAMP HUNT for any reason other than illness. I agree that CAMP HUNT has the right to reject this application at its discretion and to dismiss this child if necessary for the good of the camp. I agree that CAMP HUNT assumes no responsibility for physical injury or property loss to the herein camper, and is released from all legal liability. I give permission for CAMP HUNT to administer whatever medical treatment may be necessary, and I understand that I am financially responsible for all medical expenses incurred by this camper while in route to or from, or in residence at CAMP HUNT.

Signed: _____ Date: _____
(Parent / Guardian)

Camp Hunt

Standing Orders / Medical Provider Authorization

Camper Name: _____ D.O.B. _____

Allergies: _____

Medication	Use	Age	Dose	Allowed ?
Benadryl	Antihistamine	6-12	12.5 - 25 mg po q4-6 hrs	Yes No
Benadryl	Antihistamine	>12	25-50 mg po q4-6 hrs	Yes No
Benadryl - Topical	Itch Relief	All	2% Topical cream/lotion to affected areas	Yes No
Hydrocortisone -Topical	Itch Relief	All	1% Topical cream/lotion to affected areas	Yes No
Ibuprofen	Fever / Pain	6-12	200mg q6-8h (max 1200mg/d; take c̄ food)	Yes No
Ibuprofen	Fever / Pain	>12	200-400mg q6-8h (max 2400mg/d; take c̄ food)	Yes No
Tylenol	Fever / Pain	6-11	10-15 mg/kg (max 5 doses / 24 hrs)	Yes No
Tylenol	Fever / Pain	6-11	325 mg/q 4-6 hrs (max 5 doses/ 24hrs)	Yes No
Tylenol	Fever / Pain	>11	650 - 1000mg/q 4-6 hrs (max dose 4000mg/qd)	Yes No
Loratadine	Allergic Rhinitus	>6	10 mg / qd	Yes No
Sudafed PE -liquid	Decongestant	6-12	10ml(5mg) q4h (max 30mg/qd [6 doses])	Yes No
Sudafed PE	Decongestant	>11	10mg q4h (max 60 mg qd)	Yes No
Chlortrimetron	Allergic Rhinitis	6-12	2 mg q4-6 hrs, or 8mg q12h SR (max 12mg/d)	Yes No
Chlortrimetron	Allergic Rhinitis	>12	4 mg q4-6 hrs, or 8-12mg q12h SR (max 24mg/d)	Yes No
Chloraseptic lozenges	Minor sore throats	>5	1 tab q2h prn dissolved in mouth	Yes No
Chloraseptic Spray	Minor sore throats	2-12	3 sprays q2h prn in mouth	Yes No
Chloraseptic Spray	Minor sore throats	>12	5 sprays q2h prn in mouth	Yes No
Robitussin	Cough	All	Per label, age dependant	Yes No
Tums (Calcium Carbonate)	Dyspepsia	4-11	1 tablet after meals up to 3qd	Yes No
Tums (Calcium Carbonate)	Dyspepsia	>12	2 tablets q4h	Yes No
Junior Maalox Plus	Dyspepsia & Gas	6-11	2 tablets as symptoms occur	Yes No
Maalox Regular Strength	Dyspepsia & Gas	>11	10-20 ml qid (max 60ml qd)	Yes No
Pepto-Bismol	Dyspepsia, Diarrhea	>11	30 ml q1h prn (max 240 ml/d)	Yes No
Imodium	Diarrhea	>8	2mg q8h x 1 day, then 0.1 mg/kg after each loose stool	Yes No
Sunscreen			may self apply	**Yes No**
Insect Repellent			may self apply	**Yes No**
All the above medications approved for use as indicated				**Yes No**

Signing this document allows Camp Hunt's Medical Staff to provide the above approved medications for the listed use(s) only to the camper named above. This document is not intended to replace prescription medications which a camper may need to have provided for him/her during the time he/she is at Camp Hunt.

Provider Name: (MD, DO,RNP, PA) _____

Provider Address: (MD, DO,RNP, PA) _____

Provider Signature: (MD, DO,RNP, PA) _____