



February 2008

Dear Camper,

We are excitedly preparing for our camping sessions and need your assistance with the required paperwork. All forms must be in order to be in compliance with the New York State Department of Health guidelines, and we thank you for your cooperation in providing us with this information. The enclosed packet **MUST BE COMPLETED FOR ATTENDANCE**. Please have all forms completed at least 3 weeks prior to your camping session, and either mail or fax to the Camp office in Mendon, NY.

The following information on the "Medical Form" **MUST** be completed by you (booklet):

- General Information
- Medications
- Health Information
- Consent for Medical Treatment and Permission Slip / Waiver

Any major medical concerns that develop will be handled at either Soldiers and Sailors Hospital in Penn Yan or at Strong Memorial Hospital in Rochester. If you need lab work (i.e. blood counts) or X-Rays, your health insurance will be billed for these services. Please attach a copy of your health insurance card to the forms.

Please note that you are responsible to bring to camp any medications you take (both scheduled and "as needed") and, if applicable, supplies for your central line. This includes, but is not limited to, dressing change kits, syringes, needles, caps, saline and heparin. Your medications may be kept in the cabin with you and you will be responsible for self-administration.

Additionally, chickenpox (varicella) can be very serious for some of our campers. Please do not come to camp if there has been any contact with chickenpox within the 3-weeks prior to camp. Please call the office with any questions.

Thank you very much for your cooperation in providing us with this necessary medical information. I am available to answer any questions you may have. Please contact myself or Diane Williams at (800) 785-2135 if we can be of any assistance. We look forward to seeing you at camp!

All the best,

Shannon L. Grieve
Camp Director

(INDICATE PROGRAM NAME AND ATTACH PHOTO OF CAMPER)

CAMP GOOD DAYS & SPECIAL TIMES

1332 Pittsford-Mendon Road, P.O. Box 665 Mendon, NY 14506

General Information:

Name _____

Address: _____

City: _____ State: _____ Zip code: _____

Home phone: _____ Work/cell phone: _____

Date of Birth: _____ Current Age: _____

Emergency Contact Information:

Name: _____

Relationship to camper: _____

Address: _____

Home phone: _____

Work/cell phone: _____

Health Care Provider Information:

Institution/Hospital where you receive care: _____

Name of physician/nurse practitioner: _____

Phone Number: _____

Insurance Information:

Name of Insurance Company: _____

Policy #: _____

Health Information:

Current Medical Issues (i.e. cancer, seizures, diabetes, asthma, heart disease, etc.):

Past History of Medical Issues (i.e. cancer, injuries, seizures, etc.):

Allergies (to medications, food, insects, etc.):

Have you ever had surgery? NO YES (please elaborate and provide date)

Immunizations:

Date of last tetanus shot: _____

Have you received all of your childhood vaccines (2 MMR, 4 Polio, 5 DTP)?

YES NO (If NO, please explain _____)

Have you received your Hepatitis B series? YES (dates ____/____/____) NO

Infectious Diseases:

Have you had chickenpox or shingles? NO YES (Date: _____)

To your knowledge, have you been exposed
to chickenpox within the past 3 weeks? NO YES

Food Restrictions:

Physical Restrictions / Limitations (i.e. wheelchair, vision/hearing deficits, etc.):

Medications (Please include all scheduled **and** "as needed" prescription medications you take (i.e. asthma inhaler); You are responsible for bringing these medications to camp):

Name	Dose	Route	Schedule

Other Information: _____

Adult Camper's Name: _____

I. Consent for Medical Treatment:

I hereby grant permission to the medical staff at the Camp or consulting physicians/ nurse practitioners to administer routine and any emergency care required to myself in the event of an emergency.

I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for myself in the event of an emergency. In the event of an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment to myself, including hospitalization.

Signature

Date

II. Permission Slip/Waiver:

I hereby grant permission to participate in the 2008 Camp Good Days and Special Times, Inc. camping program.

I hereby waive and release Camp Good Days and Special Times, Inc. and everyone involved of any liability or claim in association with anything that might occur to me while attending this program.

Signature

Date

III. Photo/Audio-Visual/Media Release:

I hereby grant permission to participate in any audio-visual event (including photos and videos for future camp use) that may take place in regard to this program and release Camp Good Days and Special Times, Inc., and everyone involved of any liability or claims in association with the media coverage if such takes place.

PLEASE CIRCLE ONE: YES or NO (If No, please be aware of this responsibility)

Signature

Date

IV. Contact Information:

I hereby grant permission for my contact information (address/e-mail) to be shared with other campers/volunteers via an "address list" at the close of the camping session. Please note that phone number will not be included in the list provided by camp.

PLEASE CIRCLE ONE: YES or NO

Signature

Date

LATE CHANGES FORM

(If there are changes from original medical forms, please send this to camp with child)

Campers name: _____

Today's date: _____

Please list medication information if it is different from what is on medical form:

Name	Dose	Route	Schedule

Most Recent Blood Count:

Date: _____

Hgb: _____ Hct: _____ RBC: _____ WBC: _____ Plts: _____

Differentials: _____

Has your child had contact with chickenpox during the last 3 weeks? NO YES

Please indicate any further information about your child's medical needs you feel we should know about that is not already listed on medical forms:
