Name: _____ **State/Country:** _____

Last, First Middle – Must Match Your Identification Documents | Spell Out

FORM 6: MEDICAL INFORMATION (PAGE 1)

Delegates to the NYSCamp are required to have a physical examination by a medical professional prior to participating in the NYSCamp. Please schedule an appointment for this physical examination immediately and take this form with you to be completed and signed at the time of the physical examination. Please submit the completed form as soon as possible by uploading it as an Adobe Acrobat (*.pdf) attachment to http://forms.nyscamp.org. The information collected on this form is necessary to identify and provide appropriate medical care; provide complete information so that the NYSF can be aware of individual needs. The information provided is protected as required by the *Health Insurance Portability and Accountability Act (HIPAA)*. Any changes of the information on this form after it is submitted must be provided to the NYSF upon the participant's arrival. **You are required to provide proof of medical insurance coverage by uploading a copy of both sides of your medical insurance card to http://forms.nyscamp.org.** Be sure that the insurance card provides the following information: policy holder's name and address, employer's name, policy and/or group number, and the name and address of the insurance company. International participants will be enrolled in insurance through the State Department and DO NOT need individual insurance to participate. Please notify the NYSF if the participant is exposed to any communicable disease during the four weeks prior to arrival.

Date of Birth: _____ Age while at Camp: _____

Parent or Guardian: _____ Emergency contact, if parent not available: _____

Address: _____ Address: _____

_____ _____

Phone: _____ or _____ Phone: _____ or _____

Explain any restrictions to activity and required accommodations on the Medical Information (Supplemental Page).

Permission to Provide Medical Treatment or Emergency Care:

As the legally recognized parent or guardian of the individual named above, by signature below, I hereby give authority and permission to the National Youth Science Foundation, its staff, and licensed medical professionals to obtain and provide necessary medical treatment, including, but not limited to, diagnostic X-rays, routine tests, and treatment, including hospitalization; to release any records necessary for medical or insurance purposes; to provide or arrange necessary related transportation for my child; to administer, as needed, the over-the-counter medications listed below (strike through any exceptions); and to copy this completed form (to accompany the participant on trips outside of our facility). I understand that every practical effort will be made to contact me or other parents or guardians of the participant if a medical emergency occurs.

Over-the-Counter Medications and indications:

- Sunscreen and insect repellant, topically
- Dayquil, Nyquil, for cold symptoms
- Antacid, for upset stomach
- Milk of Magnesia, for constipation
- Imodium, for diarrhea
- Calamine/hydrocortisone, topically, for itch/contact dermatitis
- Bacitracin/Triple Antibiotic Ointment, topically, for infection prevention
- Robitussin (Guaifenesin), per weight/age dosing for cough
- Benadryl (Diphenhydramine) oral, per directions for weight/age for rash/itch, rhinitis, sneezing, itchy eyes without acute asthma episode
- Tylenol, per weight/age dosing, for pain, fever, headache
- Motrin, per weight/age dosing, for pain
- Throat lozenge, for sore throat
- Dramamine (Dimenhydrinate)/meclizine, for motion sickness
- Epinephrine and Benadryl, for severe anaphylactic reaction

_____ _____

Parent or Legal Guardian's Signature Date | Participant's Signature Date

Please remember to enclose a copy of both sides of your medical insurance card along with this completed form.

I understand and agree to the above and to abide by any and all restrictions placed on my camp activities.

General Questions

Has/does the participant:	Yes	No		Yes	No
1. Have a life-threatening allergy?	○	○	17. Ever had back problems?	○	○
2. Had any recent injury, illness or infectious disease?	○	○	18. Ever had problems with joints? (e.g. knees, ankles)?	○	○
3. Have a chronic or recurring illness/condition?	○	○	19. Have any skin problems?	○	○
4. Ever been hospitalized?	○	○	20. Have diabetes?	○	○
5. Ever had surgery?	○	○	21. Have asthma?	○	○
6. Have frequent headaches?	○	○	22. Had mononucleosis in the past 12 months?	○	○
7. Ever had a head injury? Concussion?	○	○	23. Had problems with diarrhea/constipation?	○	○
8. Ever been unconscious from a blow to the head?	○	○	24. Have problems with sleepwalking?	○	○
9. Wear eyeglasses, contacts, or protective eye wear?	○	○	25. If female, have an abnormal menstrual history?	○	○
10. Ever had frequent ear infections?	○	○	26. Have a history of bed-wetting?	○	○
11. Ever passed out during or after exercise?	○	○	27. Ever had an eating disorder?	○	○
12. Ever been dizzy during or after exercise?	○	○	28. Ever had mental health difficulties requiring professional help?	○	○
13. Ever had seizures?	○	○	29. Have anxiety?	○	○
14. Ever had chest pain during or after exercise?	○	○	30. Have depression?	○	○
15. Ever had high blood pressure?	○	○	31. Have a gastro-intestinal problems?	○	○
16. Ever been diagnosed with a heart murmur?	○	○	32. Have any other medical or psychological conditions?	○	○

Use the Medical Information (Supplemental) page to explain each "yes" answer, noting the number of the question.

Please upload each form to http://forms.nyscamp.org as soon as it is completed.

Name: _____ **State/Country:** _____

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FORM 6: MEDICAL INFORMATION (PAGE 2)

Immunizations (Please fill out as completely as possible.) ***Participants are required to have a tetanus immunization before participation.***

Which of the following diseases/illnesses has the participant had?

○ Measles
○ Chicken pox
○ German measles
○ Mumps
○ Hepatitis

TB Test
Date of last test _____
Result: ○ Positive ○ Negative

Please give all dates of immunization for:

Vaccine: Date:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP / TDAP	_____	_____	_____	_____	_____	_____	_____
TD (tetanus/diphtheria)	_____	_____	_____	_____	_____	_____	_____
Tetanus*	_____	_____	_____	_____	_____	_____	_____
Polio	_____	_____	_____	_____	_____	_____	
MMR	_____	_____					
or Measles	_____	_____					
or Mumps	_____	_____					
or Rubella	_____	_____					
Haemophilus influenza B	_____	_____	_____	_____			
Hepatitis B	_____	_____	_____				
Varicella (chicken pox)	_____	_____					
BCG	_____						

Physical Examination (This portion must be completed by a licensed medical professional.)

A check mark (√) indicates "satisfactory." Please explain unsatisfactory categories on the **Medical Information (Supplemental)** as necessary.

_____Height
_____Weight
_____Blood Pressure
_____Eyes
_____Ears
_____Nose
_____Teeth
_____Throat
_____Heart
_____Lungs
_____Abdomen
_____Genitalia
_____Hernia
_____Posture (spine)
_____Extremities
_____Skin
_____Urinalysis Test
_____Hemoglobin Test

General Appraisal _____

Recommendations and Restrictions: _____

Allergies – List all known allergies. (This portion must be completed by a licensed medical professional.)

Allergen	*Life Threatening?*	*Describe Reaction*	*Describe Management*
	○ Yes ○ No		
	○ Yes ○ No		
	○ Yes ○ No		
	○ Yes ○ No		

Life threatening allergies: please describe the reaction and management plan on the Medical Information (Supplemental) page.

Medications (This portion must be completed by a licensed medical professional.)

Please list ALL medications, including over-the-counter or non-prescription drugs, taken routinely. Bring sufficient amounts of medication to last the entire time at camp. Keep these medications in the original package or bottle that identifies the prescribing physician (if a prescription drug), the name of the participant, the name of the medication, the dosage, and the frequency of administration. Each participant is responsible for taking daily medications and storing them properly and securely.

This person takes medications as follows (please attach additional pages as necessary):

Med #1_____ Dosage_____ Specific times taken each day_____
Reason for taking_____

Med #2_____ Dosage_____ Specific times taken each day_____
Reason for taking_____

Licensed Medical Professional's Information (must be a MD, DO, PNP, NP, PA or equivalent).

_____ _____
Name (please print) **Address**

_____ _____
Telephone number (including area code)

PLEASE SIGN HERE

_____ _____
Licensed Medical Professional's Signature **Date**

This health history is correct and complete as far as I know.

PLEASE SIGN HERE

_____ _____ _____ _____
Parent or Legal Guardian's Signature **Date** **Participant's Signature** **Date**

Please upload each form to http://forms.nyscamp.org as soon as it is completed.

Name: _____ **State/Country:** _____

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FORM 6: MEDICAL INFORMATION (SUPPLEMENTAL)

- Please use this page to describe any and all "yes" answers to the general questions on page 1.
- Please use this page to describe any and all **life threatening** allergies by clearly identifying the allergen, the reaction, and the management plan including any requested accommodations. Please identify the allergy clearly as life threatening. The NYSF will make reasonable accommodations on request, but cannot guarantee every requested accommodation. If the management plan includes potential use of an EPI pen, the participant is responsible for supplying at least 2 EPI pens and must keep them on their person at all times.
- Please make additional copies of this page as necessary.
- Each page must be signed individually by a medical professional.

PLEASE SIGN HERE

Licensed Medical Professional's Signature **Date**

Please upload each form to http://forms.nyscamp.org as soon as it is completed.