CAMP NESIOT

Mail: 847 east 13th Street, Brooklyn, NY, 11230 OR
110A Sunset Road, Lakewood, NJ 08701
Email to: c.saposh@nesiottours.com

Confidential Medical and Consent Form PART I to be completed by Parent.

Camper's Name _____ Date of Birth_____ Age _____

Home Address_____ City, State, Zip_____

Contact Information

	Mother	Father	Emergency Contact
Name			
Home Phone			
Work Phone			
Cell Phone			
Summer Phone			
Email			

Which parent/guardian should be called first in case of emergency?_____
Has child ever had an anaphylactic reaction? ☐ No ☐ Yes – if yes, you must send an Epi Pen to avoid charges(Check Exp Date)
Physician's Name and Phone Number _____

AUTHORIZATION TO CONSET TO TREATMENT OF MINOR TEMPORARILY SEPARATED FROMN HIS PARENTS

I/We, the undersigned, parent(s) of _____a minor, do hereby authorize Camp Nesiot to consent to any diagnostic procedure or medical care which is deemed advisable by, and is to be rendered under the general or special supervision of, any licensed physician and surgeon.

This authorization shall remain effective until August 30th, 2022, unless sooner revoked in writing delivered to said agent(s).

Parent Signature_____ **Date** _____

Authorization to Release Information & Assignment of Benefit

I authorize the release of any medical information necessary to process this claim.
I hereby authorize, Camp Nesiot to apply for benefits on my behalf for services rendered by them.
I certify that the information I have reported above is correct. I am aware of new Federal Health Information Portability and Accountability Act (HIPAA)
Signature: _____ Print Name:_____ Date:_____

MEDICAL AND PRESCRIPTION DRUG INSURANCE INFORMATION
Please attach a copy (front and back) of your medical and prescription card here. If no card is attached, you will be responsible for all medical and drug charges.

☐ I do not have medical coverage

☐ I do not have prescription coverage

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IMMUNIZATION RECORD – PART 2- To Be Completed By Examining Physician

Camper's Name_____

IMMUNIZATION HISTORY: Please record month and year of basic immunizations and most recent Booster.

Immunization	Date Basic Series Completed	Most Recent Booster
DPT or DT		
TETANUS		
OARL POLIO		
MMR		
MEASLES		
MUMPS		
RUBELLA		
PPD MANTOUX		
HEPATITS A		
HEPATITS B		
VARICELLA		
INFLUENZA		
MENINGOCOUL MENINGITIS		

Medical History Date of Illness

Chicken Pox

Measles _____

German Measles _____

Mumps _____

Hepatitis _____

Pneumonia _____

◯ Positive PPD Date _____ CX-Ray Date ____

Indicate if being treated for the following:

Diabetes_____ Seizures _____

Seasonal Allergy_____ Rheumatic Fever ___

Frequent: Ear Infections____ Strep Throat _____

Asthma

(If your child is being treated for asthma please send along the tubing for the nebulizer)

Chronic or Recurrent Illness and Suggested Treatment-

_____

ALLERGIES	Yes	No	Comments
Bees/ Insect Bites			
Penicillin			
Sulfa			
Cephalosporin's			
Other Medications			
Food (list food child is allergic to)			

If your child is coming to camp with a year-round prescription medication, you must complete a separate *Permission for Administration of Medication Form* for each medication prescribed, detailing the dosage, time and frequency it should be taken, as well as the reasons for taking the medication.

Special Restrictions:

Diet _____

Swimming _____

Strenuous Activity_____

Other _____

To the best of my knowledge the information stated above is true and accurate and it is my opinion that the camper listed above is physically able to engage in all camp activities, except as noted above. While the health code requires a current, confidential, medical history, updated annually, to be on file, it is preferable for your child to be seen and be signed by his doctor, prior to camp.

Doctor's Name _____ Phone Number _____

Physician's or Parent's Signature Date

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TO BE COMPLETED BY PARENTS

Please detail any special circumstances or conditions that our staff should be aware of that will assist us in the care of your child (e.g. special diets, frequent infections, stomach aches, constipation, bedwetting, sensitivity to insect bites, hives, anxiety, fainting, etc.) and what you recommend as treatment:

_____

_____

MEDICAL INSURANCE COVERAGE

BASIC INSURANCE CARRIER _____ POLICY HOLDERS NAME & RELATION _____
GROUP NAME AND NUMBER _____ ID# _____
OTHER SECONDARY INSURANCE CARRIER AND ID# _____
PRESCRIPTION PLAN # _____

PARENTS' AUTHORIZATION TO TREAT & MENINGITIS VACCINATION RESPONSE –SIGNATURE REQUIRED TO ATTEND CAMP

1. This health history is so far correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted by me and the examining physician.
2. I hereby give permission to the physician selected by the camp director to order X-rays, routine tests and treatments for the health of my child, and in the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for my child as named above.
3. I have read the camp letter describing Meningitis, its transmission, the benefits, risks and effectiveness of immunization, availability and cost. (Please CHECK ONE BOX and SIGN BELOW)
   - ☐ My child has had the meningococcal meningitis immunization (Menomune™) within the past 10 years. Date received:_____
   - ☐ 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 <u>not</u> obtain immunization against meningococcal meningitis disease.

Parent's Signature_____ Witness_____ Date _____

CAMP NESIOT

MEDICAL & PRESCRIPTION DRUG INFORMATION

PASTE A COPY OF THE FRONT OF YOUR MEDICAL INSURANCE CARD HERE

PASTE A COPY OF THE BACK OF YOUR MEDICAL INSURANCE CARD HERE

Policy in the name of: _____

Relationship: _____

PASTE A COPY OF THE PRESCRIPTON DRUG CARD HERE

- ☐ My medical & drug coverage is the same. A copy of my card is already attached
- ☐ **I do not have drug coverage**

Policy in the name of: _____

Relationship: _____