Syracuse University Clinic and Camp Health Form - 2019

A sports camp or clinic participant will not be permitted to attend a camp or clinic unless this form is completed, ***in it's entirety****, and returned no later than one week prior to registration. On-site registrants must have a completed form before participation will be permitted. PLEASE PRINT CLEARLY*

THOSE PARTICIPANTS REQUIRING TAPING OR SPLINTING FOR SPORTS PARTICIPATION MUST SUPPLY THEIR OWN TAPING AND SPLINTING SUPPLIES FOR PRE-EXISTING CONDITIONS.

Participant's Name: Gender : (circle one) Male Female

Last Name First Name

Participant's DOB: / / Age: Sport: Camp/Clinic name:

Parent/Guardian: Home Phone: ( )

Email address: Cell Phone: ( )

Address:

Street Number City State ZIP

If not available in an emergency, notify: 1 Number:

2 Number:

*******Please include a copy of your insurance card AND complete the following*******

Insurance Company:	Policy Holder Name:
Policy #	Policy Holder DOB: / /
Group #:	Relation to Camper:
Primary Care Physician:	Policy Holder Employer
Pre-approval Required? (circle one) YES NO	Insurance Company Phone Number:

Immunization History - Please INCLUDE A COPY of CAMPER immunization record. Must have 1 MMR	**General Medical Information -** Asthma: (Circle one) YES NO
List Current Medications:	Allergies:
	Food:
	Medications:
IF CAMPER IS BRINGING MEDICATION TO CAMPUS	Bee Stings:
PLEASE FILL OUT MEDICATION AUTHORIZATION FORM	Other:

PARTICIPANTS with the following conditions must provide written physician's clearance before attending a Syracuse Camp or Clinic. Please return an OFFICIAL LETTER of physician's clearance (for each item) with the form. Participants without official physician clearance will be withheld from competition until clearance is received in writing.

Please specify the condition in the space provided:

Fracture in the last 6 months:	Surgery in the past year:
Seizure disorder(anytime period):	Heart Condition(anytime period):
Diabetes(anytime period):	Hemophilia/blood disorder(anytime period):
Loss of organ(anytime period):	Hospitalization in last 6 months:
Spinal, head injury or concussion:	Other Injury/Illness requiring ongoing care:

PARENT/GUARDIAN AUTHORIZATION and NOTIFICATION;

Meningococcal Meningitis is a bacterial illness affecting the brain. It can be spread by a cough, sneeze, kiss, sharing drinks, or by any other direct contact or airborne means of transportation. Therefore, students/campers residing in small areas, such as dormitories, are at an increased risk for contracting the illness.

The signs and symptoms of Meningococcal Meningitis are similar to the common flu often making it hard to detect. The signs and symptoms include the following: high fever, nausea, vomiting, fatigue, headache, stiff neck/back, skin rashes, and confusion. Frequently, not all signs and symptoms occur, and the illness may progress rapidly. Treatment of Meningococcal Meningitis is antibiotic therapy.

A vaccination is available, and is an effective way to help prevent Meningococcal Meningitis, although any vaccine is not an absolute guarantee. There are rarely side effects associated with this vaccination. **Syracuse University summer camps will not provide the Meningitis vaccine.** Contact your family care provider for information regarding availability and associated costs of the vaccination.

I, the parent of legal guardian have received, reviewed, and understand the above information regarding Meningococcal Meningitis and my son/daughter has either received the immunization within the past 10 years preceding or has elected not to obtain the immunization against Meningococcal Meningitis.

To the best of my knowledge this health history information is correct and the person herein described has my permission to engage in all camp activities, with the exception of any physical limitations as described. In the event that I cannot be reached in an emergency, I hereby give permission to the medical personnel to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery for my child as named above. I agree to indemnify Syracuse University and its employees for any claim which may hereafter be presented by our (my) son/daughter as a result of any such injuries.

Signature: Date:

Witness: Date:

***Please use the cups provided at each drinking station when utilizing the Gatorade/water. No use of personal cups or containers!**

SYRACUSE UNIVERSITY SUMMER CAMP

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION BY YOUTH CAMP PERSONNEL

If a summer camp chooses to administer medication, the Onondaga County Department of Health requires an authorized prescriber (M.D., P.A, APRN) or dentist's written order and parent or guardian's authorization for camp personnel to administer medications prescribed or over the counter medications. All medications must be in pharmacy prepared containers and labeled with the name of the child, name of the drug, strength, dosage, frequency, authorized prescriber, or dentist's name and date of the original prescription. Over the counter medication must be in the original container and labeled with the child's name.

AUTHORIZED PRESCRIBER OR DENTIST'S ORDER DATE _____/_____/_____

Name of Camper_____Date of Birth_____/_____/_____
Street Address_____City_____State_____
Condition for which medication is being administered during camp hours_____

Medication (Name, dose, method of administration) _____Is this a controlled drug? Y N

Times of Administration: Breakfast Lunch Dinner Bedtime As Needed Other:_____
Medication shall be administered from ____/___/____ to ____/___/____
Relevant side effects to be observed, if any _____
If there are side effects, plan for management _____
Allergies, reaction to, or negative interaction with food or drugs? If YES, explain/list_____

Authorization by <u>Prescriber</u> for administration of above medication:

Prescriber's Name_____Phone(____) _____

Address_____City_____State_____

Prescriber's Signature_____Date_____

Authorization/Approval for <u>Self-Administration</u> of above medication:

<u>Self-administration</u> of medication may be authorized by the prescriber and parent/guardian approval for only <u>asthma medication and epi-pens.</u> SU camp personnel may witness the self-administration.

Prescriber's authorization for self-administration: YES NO _____
Signature Date

Parent/Guardian's authorization for self-administration: YES NO _____
Signature Date

Authorization by Parent/Guardian for the administration of the above medication:

I have legal authority to consent to medication administration for the camper named above, including the administration of medication. I hereby request that the above medication, ordered by the authorized prescriber for my child be administered by the camp personnel designated by the Camp director. I understand that I must supply the summer camp with the prescribed medication in the original container and properly labeled by an authorized prescriber, dentist, or pharmacist. Over the counter medication shall be in the original container labeled by the parent with the child's name. I understand that this medication will be destroyed if it is not picked up within one week following termination of the order/camp. I agree to indemnify and hold harmless the Summer Camp Program Staff, Syracuse University, its Board of Trustees, officers and employees against any claims that may arise relating to my child's self-administration of medication.

Parent/Guardian Name_____Relationship_____
Address_____City_____State_____Phone (___) _____
Parent/Guardian's Signature_____Date_____