



Greenkill Outdoor Environmental Education Center
YMCA Camping Services of Greater New York
2008-2009 Program Participation & Health Form

School: _____ Dates of Greenkill Experience: _____

Students Name: _____ Male / Female (Please circle)
Last First MI

Age: _____ Birth date: _____ Greenkill Birthday! Yes / No (Please circle)

Contact information:

Name of Parent/Guardian: _____ Relationship: _____

Home Address _____
Street Apt.# City State Zip

Home: () _____ Work: () _____ Cell: () _____

Name of Emergency Contact: _____ Relationship: _____

Home: () _____ Work: () _____ Cell: () _____

Food / Dietary Needs:

Please notify and talk with the school regarding dietary needs. The school will coordinate with Greenkill to ensure each students needs are met.

Health Concerns: It is extremely important that the school be advised of any/all health care matters regarding your child. Please note here any information that will be important for the Greenkill instructional staff to be aware of in order for them to provide a safe and positive experience for your child.

Limited participation: Please understand that the students will be participating in Outdoor Environmental Education program which will include some physical activities, it is important to inform school of any activities which your child should not, or might have difficulty participating in:

Has this student ever required any psychiatric counseling or hospitalization? Yes / No (Please circle)

Explain _____

Operations or serious injuries (dates) _____

Name of family physician _____ Phone _____

Date of last physical examination _____

Do you carry family medical/hospital insurance? Yes _____ No _____

If yes, indicate: Carrier _____ Policy or Group # _____

Emergency Authorization REQUIRED

This health history is correct so far as I know, and the person herein described has permission to engage in all activities in the Greenkill Outdoor Environmental Education at YMCA Camping Services program except as noted above.

Permission to Treat: I hereby give permission to the medical personnel selected by the school and/or YMCA to provide routine health care; to administer medications; to order x-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me or my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the school and/or YMCA to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

Signature of parent/guardian: _____

Date: _____

PHYSICIAN—PLEASE FILL OUT BOTH PARTS!!

For medications to be dispensed by a nurse the following must be completed by the licensed health care prescriber AND signed by parent/guardian:

Prescription and over the counter medications:

I request that my patient as listed below, receive the following prescription medication(s) including prn's:

Name of student: _____ Date of Birth: _____

Diagnosis: _____

Name of Medication(s) with the prescribed dosage, frequency and route of administration:

- 1). _____
- 2). _____
- 3). _____
- 4). _____

Standard Over the Counter Medications

The following medications are available in the Health Center with parent/guardian and physicians approval. Please select which medications below can be administered.

| Drug Name | Route | Dosage | Schedule | Indication | Comments |
|----------------------------|-------------------------------------|----------|-------------------|---|----------|
| Ibuprofen / Ibuprofen | PO (Chewable tabs, pills or liquid) | _____ mg | Every _____ hours | For pain or fever | |
| Tylenol / Acetaminophen | PO (Chewable tabs, pills or liquid) | _____ mg | Every _____ hours | For pain or fever | |
| Robitussin / Robitussin DM | PO (liquid) | _____ cc | Every _____ hours | For cough | |
| Benadryl / Diphenhydramine | PO / Topical (pills, liquid) | _____ mg | Every _____ hours | For allergy symptoms | |
| Benadryl spray | Topical spray | | Every _____ hours | For bug bites and skin rashes | |
| Calamine | Topical lotion | | Every _____ hours | For bug bites and skin irritations | |
| Bacitracin | Topical | | Every _____ hours | For splinters, cuts, abrasions and skin irritations | |

Licensed Physician's Signature _____ License # _____

Address _____ Phone (____) _____

Date of Form Completion _____ By _____
 Initial if completed by nurse or physician's assistant

Parent / Guardian Signature _____ Date _____