NEW YORK STATE SHERIFFS' INSTITUTE, INC

2024 SUMMER CAMP APPLICATION **Week _____**

This page is to be filled in by Parent or Guardian of camper. Complete all questions. PLEASE PRINT CLEARLY.

Camper Name _____ **Birth date** _____ **Gender** ____ **Grade** _____ **Age** _____

Parent or Guardian _____

Phone: Home (____) _____ Cell (___) _____ **Relation to camper** _____

Email(s) _____

Home Address _____ **County** _____

If not available, in an emergency notify:

1. **Name** _____ **Relation** _____ **Phone** _____
2. **Name** _____ **Relation** _____ **Phone** _____

HEALTH HISTORY (Please indicate with an X)

Medications _____ **Inhaler** _____ **EpiPen** _____ **Allergies** _____ **Bed wetter** _____

Please answer all these questions. Do not leave any answers blank. Write "None" if there is none.

Physical Health Issues/Diagnosis _____

_____

Mental Health or Behavioral Issues/Diagnosis _____

_____

Medications that will be brought to camp (detailed info to be provided by doctor on Page 4) _____

_____

Additional Information Camp should know about _____

_____

****************PARENT/GUARDIAN AUTHORIZATION (required)***************

This health history is correct so far as I know, and the person described herein has permission to engage in all prescribed camp activities, except as noted by me and the examining physician. In the event I cannot be reached in an EMERGENCY situation, I hereby give permission to the physician selected by the Camp Director to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child named above. In addition, I give permission to the NYS Sheriffs' Institute, Inc. to use pictures taken of my child while attending summer camp. I also authorize my child to carry and apply sunscreen and/or bug spray as necessary. If needed, camp staff may help my child apply either.

I will notify camp if this camper is exposed to any communicable diseases during the 3 weeks prior to attending camp.

Parent/Guardian Signature _____ **Date** _____

THIS PAGE IS TO BE COMPLETED, SIGNED AND DATED BY PHYSICIAN/ PA/ NP.

Camper Name _____ **County** _____ **Week** _____

IMMUNIZATION HISTORY- An immunization summary from a medical office can be submitted instead of filling in dates below.

_____ _____ _____ _____ _____
Diphtheria, Tetanus and Pertussis Vaccine **(DTP, DtaP)**

_____
Tetanus, Diphtheria and Pertussis Booster**(Tdap)**

_____ _____ _____ _____
Polio **(IPV or OPV)**

_____ _____
Varicella

_____ _____
Measles, Mumps, Rubella **(MMR)**

_____
Meningococcal (Recommended/not required)

_____ _____ _____
Hepatitis B

_____ _____ _____
Covid 19 Vaccine (Recommended/not required)

This examination must be performed within 12 months of arrival at camp. Physical examination for some other purpose within this period is acceptable. Examination is for determining fitness to engage in strenuous activities.

CODE: S- satisfactory X- not satisfactory O- not examined

Height _____ Weight _____ BP _____
Eyes _____ Glasses _____
Ears _____
Nose _____
Throat _____
Teeth _____
Heart _____
Lungs _____
Abdomen _____
Hernia _____
For Girls: Has this person menstruated? _____
If yes, is her menstrual history normal? _____

Hgb test _____ Urinalysis _____
Extremities _____
Posture (Spine) _____
Skin _____
Allergy _____
Specify Allergies _____
_____
General Appraisal _____
_____
_____
If not, has she been told about it? _____
Special considerations? _____

Recommendations and restrictions while at camp:

Special Diet _____

Will medications be sent to camp? _____ If yes, page 4 must be completed with details.

Able to swim? _____

Participate in strenuous activity? _____

Other recommendations and/or restrictions? _____

I have examined the person described herein and have reviewed his/her health history. It is my opinion that he/she is physically able to engage in camp activities, except as noted above.

Physician/PA/NP Signature and Title _____ MD PA NP (circle one)

Date of physical_____

Date form completed _____

Address _____

Phone _____

Camper Name _____ **County** _____ **Week #** _____

Over- the Counter Medications/Topicals Permission

The following medications/topicals will be available for common ailments/complaints campers may experience while at camp. They will only be dispensed if we have medical permission. Please indicate whether the medications listed may be dispensed to your camper, and sign the bottom, along with medical staff signature.

Any other Over-the-Counter medications not listed on this form will need to be included on the Page 4 Medication Form that is also used for all Prescription Medications.

Medication	Yes (Y) or No (N)		Medication	Yes (Y) or No (N)	
Hydrocortisone Cream	Y	N	Sterile Eye Wash	Y	N
First Aid/Neosporin Cream	Y	N	Eye Drops	Y	N
Calamine/Caladryl Lotion	Y	N	Ear Drops	Y	N
Anti Itch Spray	Y	N	Vaseline for Dry Lips	Y	N
Aloe/Burn Gels	Y	N	Tums	Y	N
Hurt Free Antiseptic Liquid	Y	N	Throat/cough lozenges	Y	N

Parent/Guardian Name Printed _____

Parent/Guardian Signature _____

Physician/PA/ NP Name _____

Physician/PA/ NP Signature _____

Date Sheet Filled Out _____

Camper Name _____ County _____ Week # _____

Prescription and additional Over-the-Counter Medication Detail

All Medications (prescription and over-the-counter) must be in original bottles, with original labeling and packaging. All medications (prescription and over-the-counter) must be detailed on this sheet and authorized by a physician/PA/NP. We are unable to accept loose, unlabeled, or unpackaged medications. We are unable to dispense any medications (prescription and over-the-counter) that are not authorized by a physician/PA/NP.

Details below must include the name of the medication (prescription and over-the-counter), the dosage indicated, the time of day to be dispensed and the reason for the medication. Also, please indicate any special conditions for taking the medication (example: taken with food).

Also, please be sure to include any inhalers or epi-pens, along with the reason for them.

Please include this form with your application.

Also, please make a copy of this form to include in a zip-lock bag with your camper's medications. Please have an updated form if there have been any medication changes since application. Clearly label this bag with your child's name and county. This bag will be given to the camp nurse upon arrival.

Name of Medicine	Dosage to be taken and Time of Day	Reason for Medicine

Parent/Guardian Name Printed _____

Parent/Guardian Signature _____

Physician/PA/ NP Name _____

Physician/PA/ NP Signature _____

Date Sheet Filled Out _____