



# Frost Valley YMCA Wellness Center

2000 Frost Valley Road, Claryville, NY 12725

Ph: (845)985-2291 Fax: (845)985-0059 FrostValley.org



School \_\_\_\_\_ Lead Teacher \_\_\_\_\_

## School Representative Health Form

(Teachers, Administrators, Chaperones and Parents)

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Phone number: (home) \_\_\_\_\_ (work) \_\_\_\_\_ (cell) \_\_\_\_\_

Home Address \_\_\_\_\_

Family Physician \_\_\_\_\_

### In an emergency contact:

Name \_\_\_\_\_ Phone \_\_\_\_\_

### Health History: (please check all that apply and explain):

<input type="checkbox"/> Asthma	<input type="checkbox"/> Glasses/contact lenses	<input type="checkbox"/> Heart disease/defect
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Eating disorders	<input type="checkbox"/> Nose bleeds
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Respiratory disorder	<input type="checkbox"/> Ear infections
<input type="checkbox"/> Seizure disorder	<input type="checkbox"/> Sleep walking	<input type="checkbox"/> Chicken pox
<input type="checkbox"/> Headaches		<input type="checkbox"/> Other

Comments: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Any known allergies (Food or Drug): \_\_\_\_\_

Diet Restrictions \_\_\_\_\_

Date of Last Tetanus Shot \_\_\_\_\_

### Please indicate all prescribed and over the counter medications currently taking:

Medication	Dosage	Time	Comments

I am familiar with the program and the general nature of activities planned during the trip to Frost Valley YMCA, and to the best of my knowledge the above information is correct and I am capable of participating in all facility activities.

Signature \_\_\_\_\_ Date \_\_\_\_\_

### Chaperone waiver of liability

I hereby accept any and all responsibility for, and assume the risk of any and all injury or damage to my person which might arise directly or indirectly as a result of, and or participation in the Frost Valley YMCA program. I hereby expressly release, discharge and hold harmless from any liability whatsoever the Frost Valley YMCA program and all employees and volunteers in their capacities as representatives of the YMCA. Except for injuries caused intentionally, or by willful misconduct, I certify that I am familiar with the contents of this release, that I have read and understand the same, and that it is my intention by signing this release that the same is binding not only of me, but my heirs, administrators, executors, successors and assigns.

Signature \_\_\_\_\_ Date \_\_\_\_\_

### Chaperone Model and Statement Release

Periodically, Frost Valley YMCA uses photos and statements made by participants in the Frost Valley YMCA programs for newsletters, fund raising efforts, brochures and articles about Frost Valley YMCA. All photos and statements are used with reasonable judgement for purposes directly relating to the operations of Frost Valley YMCA. This signed form gives Frost Valley YMCA permission by the signer to utilize participant photos or statements for the purposes mentioned above.

Signature \_\_\_\_\_ Date \_\_\_\_\_



# Frost Valley YMCA Wellness Center

2000 Frost Valley Road, Claryville, NY 12725

Ph: (845)985-2291 Fax: (845)985-0059 FrostValley.org



DATE OF TRIP FROM \_\_\_\_\_ TO \_\_\_\_\_

School \_\_\_\_\_ Lead Teacher \_\_\_\_\_

### Student Health Information

Student Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Parent/Guardian's Name \_\_\_\_\_

Phone Number: (home) \_\_\_\_\_ (work) \_\_\_\_\_ (cell) \_\_\_\_\_

Home Address \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone \_\_\_\_\_

Insurance Company \_\_\_\_\_ ID# \_\_\_\_\_

#### In an emergency, if unable to reach parent, contact:

Name \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_

#### Health History: (please check all that apply and explain):

<input type="checkbox"/> Asthma	<input type="checkbox"/> Glasses/contact lenses	<input type="checkbox"/> Heart disease/defect
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Eating disorders	<input type="checkbox"/> Nose bleeds
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Respiratory disorder	<input type="checkbox"/> Ear infections
<input type="checkbox"/> Seizure disorder	<input type="checkbox"/> Sleep walking	<input type="checkbox"/> Chicken pox
<input type="checkbox"/> Headaches	<input type="checkbox"/> Bedwetting	<input type="checkbox"/> Other

Comments: \_\_\_\_\_

Any known allergies (Food or Drug): \_\_\_\_\_

Diet Restrictions \_\_\_\_\_

Date of Last Tetanus Shot \_\_\_\_\_

-----Cut here when needed-----

#### \*Note: 3 signatures required below\*

#### Authorization to Consent to Treatment of Minor Temporarily Separated from His/Her Parents

I, the undersigned, parent or legal guardian of (child's name) \_\_\_\_\_, a minor, am familiar with the program and the general nature of activities planned during their trip to Frost Valley YMCA, and to the best of my knowledge the above information is correct and my child is capable of participating in and has permission to engage in all activities. I do hereby authorize (School Name) \_\_\_\_\_

(Lead Teacher) \_\_\_\_\_ As our agent(s) 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 at the nearest hospital with facilities appropriate to my child's injury/illness. This authorization shall remain effective until (day after the last day of the trip) \_\_\_\_\_ unless sooner revoked in writing delivered by said agent(s).

Parent/Legal Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

#### Student waiver of liability

I hereby accept any and all responsibility for, and assume the risk of any and all injury or damage to my dependent children which might arise directly or indirectly as a result of, and or participation in the Frost Valley YMCA program. I hereby expressly release, discharge and hold harmless from any liability whatsoever the Frost Valley YMCA and all employees and volunteers in their capacities as representatives of the YMCA. Except for injuries caused intentionally, or by willful misconduct, I certify that I am familiar with the contents of this release, that I have read and understand the same, and that it is my intention by signing this release that the same is binding not only of me, but my heirs, administrators, executors, successors and assigns.

Parent/Legal Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

#### Student Model and Statement Release

Periodically, Frost Valley YMCA uses photos and statements made by participants in the Frost Valley YMCA programs for newsletters, fund raising efforts, brochures and articles about Frost Valley YMCA. All photos and statements are used with reasonable judgement for purposes directly relating to the operations of Frost Valley YMCA. This signed form gives Frost Valley YMCA permission by the signer to utilize participant photos or statements for the purposes mentioned above.

Parent/Legal Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_



## Written Doctor and Parent Permission Form

**PLEASE NOTE: All medications, vitamins, supplements, or topical treatment require written permission from a physician and parent**

Camper Last Name \_\_\_\_\_ First Name \_\_\_\_\_

D.O.B \_\_\_\_\_ Weight \_\_\_\_\_ Allergies \_\_\_\_\_

Physician's name: \_\_\_\_\_ Phone # \_\_\_\_\_

The following over the counter medications are available in the health center. It is not necessary to send these medications with the students. These medications can be administered by a Registered Nurse per label instructions by age and weight only if Parent and Physician signature is documented below. Note: All medications must be sent in original packaging.

Drug Name	Route	Schedule and Indications	To be administered if needed
Tylenol (Acetaminophen)	By mouth (chewable tabs, elixir or tabs)	Q 4h as needed for pain or fever>___-F	Yes or No
Motrin (Ibuprofen)	By mouth (chewable tabs, elixir, suspension or tabs)	Q 6h as needed for pain or fever>___-F	Yes or No
Sudafed	By mouth ( tabs)	Q 4h nasal congestion *not more than 4 doses in 24 hours	Yes or No
Cough drops	By mouth	Q 2h as needed for sore throat	Yes or No
Robitussin (Guaifenesin)	By mouth (syrup)	Q 4 h for cough	Yes or No
Dimenhydrinate	By mouth (chewable tabs) 50 mg	Q 6 h motion sickness	Yes or No
Benadryl (Diphenhydramine)	By mouth (elixir, chewable tabs or pills)	Q 6 h as needed for allergic reaction, hives, insect bites	Yes or No
Sunblock or sunscreen	Apply topically	30 minutes prior to sun exposure as needed for outdoor activities	Yes or No
Bacitracin Zinc 1%	Apply topically	Q 4 h for signs of irritation to skin	Yes or No
Hydrocortisone Cream 1%	Apply topically	Q4 h for itch	Yes or No
Claritin (loratadine) 10mg	By mouth	Daily for allergy symptoms	Yes or No
Zyrtec (cetirizine) 10 mg	By Mouth	Daily for allergy symptoms	Yes or No
Maalox 10 mg	By Mouth	For stomach upset	Yes or No

**Physician**  
 Please document below the patient's current medication regime for both scheduled and "as needed" medications routinely received by the above noted minor.

Prescribed Medication	Route	Dosage	Schedule *Be Specific* ie: (qam, qhs,bid,tid,qid)	Comments

**Self-carry medication release for Sun block, Rescue inhalers, epi-pens and insulin pumps**

We request that the above named camper/student be permitted to carry one or all of the following:

(Please check all that apply and indicate MD order above)

- Sun block     Epi-pen     Albuterol Inhaler     Proventil Inhaler     Insulin Pump Pens     Other

Comments: \_\_\_\_\_

The above noted 'self-carry' items/medications are permitted for the indicated minor at all times. He/She has been instructed by the physician and parents and acknowledges the proper understanding of the purpose, frequency and appropriate method of use of these items.

As I consider him/ her responsible, I will not hold Frost Valley YMCA personnel responsible for any errors which may arise in my child's self administration of these items/medications.

**MUST HAVE THE FOLLOWING SIGNATURES OR NO OVER THE COUNTER, PRESCRIPTION OR SELF-CARRY MEDICATIONS CAN BE ADMINISTERED AT CAMP**

**Physician /Health Care providers Signature:** \_\_\_\_\_

Phone # \_\_\_\_\_ Address: \_\_\_\_\_

**Parent Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_