



THE STATE UNIVERSITY OF NEW YORK

Potsdam

### SUNY Potsdam Summer Youth Programs Health History Report

(To be completed by a parent or guardian)

This form will be retained in the Camp Medical Director's Office and will be available to program staff in case of an emergency.

**Please Print**

Commuter  Resident

Participant's Name: \_\_\_\_\_ Sex:  Male  Female  
Last First MI

Home Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Street

City State Zip Code

Home Phone Number: ( ) \_\_\_\_\_ - \_\_\_\_\_

Primary Guardian:  Mother  Father  Both

Mother's Name: \_\_\_\_\_  
Last First MI

Address (if different): \_\_\_\_\_

Mother's Home Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

Cellular: ( ) \_\_\_\_\_ - \_\_\_\_\_ Work: ( ) \_\_\_\_\_ - \_\_\_\_\_

Father's Name: \_\_\_\_\_  
Last First MI

Address (if different): \_\_\_\_\_

Father's Home Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

Cellular: ( ) \_\_\_\_\_ - \_\_\_\_\_ Work: ( ) \_\_\_\_\_ - \_\_\_\_\_

**Emergency Notification:** You must specify a person to be notified if the above parents are unavailable. We will attempt to contact parents first. This must be a person not listed above or residing at the same residence.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code

Phone: Home ( ) \_\_\_\_\_ - \_\_\_\_\_ Work ( ) \_\_\_\_\_ - \_\_\_\_\_ Cellular ( ) \_\_\_\_\_ - \_\_\_\_\_

**Health Care Provider Information**

Primary Health Care Provider: \_\_\_\_\_ Phone Number: ( ) \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code

**For Office Use Only**

HH1: \_\_\_\_\_ HH2: \_\_\_\_\_ HH3: \_\_\_\_\_ Medications: (amt) \_\_\_\_\_ Allergies: \_\_\_\_\_

Reviewed by: \_\_\_\_\_ Ins: \_\_\_\_\_ Emerg Ct: \_\_\_\_\_ Date Received: \_\_\_\_\_

Participant's Name: \_\_\_\_\_  
 Last First MI

**Personal History** Check Yes or No in each row

	Yes	No	Comments, answer questions
Allergies, Food or Drug			
Anxiety (nervous problem)			
Asthma			Cause:
Bone, joint, muscle or other orthopedic problems			Describe:
Diabetes			
Eating Disorder			
Emotional or psychiatric problems			
Epilepsy or seizures			
Fractures (bone)			Where & Type:
Hay Fever			
Hemophilia (bleeding problem)			Type:
Other Blood Disorders			Type:
Hospitalization			When & Why:
Mental Illness			
Migraine Headaches			
Muscle weakness or paralysis			Cause / Date:
Otitis Media (ear infections)			
Pneumonia			Dates:
Shingles (Zoster)			
Sight Impairment			Glasses or Contacts (circle one)
Stomach or intestinal problems			Type & Date:
Surgery			Date & Where:
Tendonitis			Date & Where:
Thyroid problem			Type:

**Immunizations:** Indicate the dates of the immunizations that the participant has had or attach a copy of his/her immunization record.

**Date of Immunizations**

Chicken Pox (if has not had disease)				
DPT				
Tetanus/Diphtheria				
Measles (Rubella)				
Polio				
Rubella (German Measles)				
Mumps				

**Health Insurance** (Please provide specific insurance information. This information is required by the hospital when treating patients.)

Insurance Co. Name: \_\_\_\_\_ ID Number: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_ City/ State/ Zip: \_\_\_\_\_  
 Street/Box Number

Subscriber's Name: \_\_\_\_\_ Camper's relationship to subscriber: \_\_\_\_\_

Group Number: \_\_\_\_\_ Please attach a copy of family prescription / insurance card if applicable.

**Parent / Guardian Waiver**

This health history is correct to the best of my knowledge, and the person herein described has permission to engage in all prescribed program activities, except as noted by me. We do hereby waive, release, and forever discharge said organization, its staff, officers, agents, representatives, employees, and their successors and assign from any and all claims for damages occurring during the participant's stay at camp, his/her participation in activities arising from traveling to or from camp, whether said accident, injury, or loss is due to negligence or not. I hereby give my permission for routine treatment of illness and injury at SUNY Potsdam and for routine emergency medical treatment at Canton-Potsdam Hospital.

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

**HIPAA – Authorization to Disclose Information**

I, the parent or guardian of the camper attending the SUNY Potsdam Summer Youth Program, authorize the use/disclosure of the camper's individual health information to Canton-Potsdam Hospital and any other facility which is needed in the event that the camper is hospitalized. I understand that authorizing the disclosure of this health information is voluntary. I can refuse this authorization. I need not sign this form in order to receive treatment. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this information, I must do so in writing and present my written revocation to the SUNY Potsdam Center for Lifelong Education and Recreation.

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

**SUNY Potsdam Summer Youth Programs**  
**Parent and Health Care Provider's Authorization for Administration of Medication**

Sections A, B, and C must be completed by the primary health care provider if the camper will be taking **any medication** while enrolled in the camp. Section D is to be completed by the parent or guardian.

**Section A:** Camper's Name: \_\_\_\_\_ Allergies: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Age: \_\_\_\_\_

**Section B: Health Care Provider's Order for Prescription Medications and Non-Prescription Medications Not Provided by the Camp**

Diagnosis	Name of medication	Route	Dosage	Frequency

**Section C:** The following over-the-counter medications are available at SUNY Potsdam. **Health Care Provider must circle yes or no** if they wish to have their patient receive these as needed at the standard dosages and frequencies listed. Make any changes to dosage or frequency in the Comments column.

Medication	Route	Dosage	Frequency	HCP Order	Comments
Tylenol	Oral (Tabs, chew tabs)	325mg-650mg	Every 4 hours as needed for pain or fever	YES / NO	
Pepto-Bismol	Oral (Liquid, chew tabs)	15ml-30ml (as directed on bottle)	Every 30 minutes up to 1 hour as needed for diarrhea	YES / NO	
Benadryl	Oral (Liquid, tabs, or chew tabs)	25mg-50mg	Every 4-6 hours for allergic reactions (hives, insect bites)	YES / NO	
Midol	Oral (Tabs)	As directed on package.	Every 4-6 hours for menstrual cramps	YES / NO	
Ibuprofen	Oral (Tabs)	200mg-400mg	Every 6 hours as needed for pain	YES / NO	

Health Care Provider's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

License Number: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

**Authorization to carry EPI Pen / Rescue Inhaler Only**

Condition	Medication (circle one)	Health Care Provider's Signature	Parent / Guardian's Signature
	EPI PEN / Rescue Inhaler: (Name)		
	EPI PEN / Rescue Inhaler: (Name)		

**Section D:** To be completed by the parent or guardian

**All campers must have this form on file to stay at camp.**

- Written authorization by a parent /guardian and the health care provider is necessary for a camper with a severe medical condition to carry an epi pen or rescue inhaler. Parents will be notified and campers will be sent home if they carry medication without proper authorization from a licensed health care provider and parent/guardian.
- I give permission for my child \_\_\_\_\_ to receive the medication(s) as prescribed above by our licensed health care prescriber. The medication listed in Section B is to be provided by me in the **properly labeled original container from the pharmacy**. Medication listed in Section C will be provided by SUNY Potsdam Summer Camps. I understand that my child will be supervised by the SUNY Potsdam Summer Camp Health Staff in taking his/ her own medications.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Camp Child is Attending:  Bears Basketball Camp  Crane Youth Music  NCSTEP  Swim Camp  Football Camp