

MEMORANDUM

To: Camper Parents\Guardians
Date: January, 2016
Re: HIPAA Update

MEDICAL AUTHORIZATION

I _____ parent or guardian of _____
Please Print Name *Please Print Name*

authorize any physician, nurse or other health care provider, to communicate with the medical staff and directors of the New Jersey 'Y' Camps, or his/her designee, about my child's medical condition, treatment, and/or prognosis.

We further authorize the camp medical staff to discuss any medical conditions with the director, his/her designee, or the child's counselor when the medical staff, in its sole discretion, believes such communication to be in the best interest of the child.

These authorizations are limited to June, 2016 through August, 2016.

Parent/Guardian Signature

Date

Return this form and your child's health form to your JCC or Y Camp Office.
Please DO NOT send to NJY Camps.



CAMPER HEALTH HISTORY

Developed and reviewed by: American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses

Mail this form to the address below by June 1

YOUR JCC CAMP OFFICE:

Camp Deeny Riback

Please DO NOT send to NJY Camps

Dates will attend camp: from _____ to _____
Month/Day/Year Month/Day/Year

Camper Name: _____
First Middle Last

Male Female Birth Date _____ Age at camp: _____
Month/Day/Year

To Parent(s)/Guardian(s): Please follow the instructions below. Attach additional information if needed.

- 1) Parent/Guardian should complete CAMPER HEALTH HISTORY (pages 1, 2, 3) and make a COPY
- 2) Send the signed form (pages 1,2,3) to the camp office ASAP -- no later than May 15.
- 3) Complete the top of CAMPER HEALTH-CARE RECOMMENDATIONS (page 4) and provide the copy of pages 1,2,3 to your child's health-care provider for review and completion. If your physician uses own form for immunizations or exam, you may attach to camp form.
- 4) After it has been completed and signed by your child's health-care provider, make a copy of page 4 for your records and return the original to the camp office by May 15.

Camper Home Address: _____
Street Address City State Zip Code

Parent/guardian with legal custody to be contacted in case of illness or injury:

Name: _____ Relationship to Camper: _____ Preferred Phones: (_____) (_____) Email: _____

Home Address: _____
(If different from above) Street Address City State Zip Code

Second parent/guardian or other emergency contact:

Name: _____ Relationship to Camper: _____ Preferred Phones: (_____) (_____) Email: _____

Additional contact in event parent(s)/guardian(s) can not be reached:

Name(s): _____ Relationship to Camper: _____ Preferred Phones: (_____) (_____)

Allergies: No known allergies. This camper is allergic to: Food Medicine The environment (insect stings, hay fever, etc.) Other
(Please describe below what the camper is allergic to and the reaction seen.)

Diet, Nutrition: This camper eats a regular diet. This camper eats a regular vegetarian diet.
 This camper has special food needs. (Please describe below.)

Restrictions: I have reviewed the program and activities of the camp and feel the camper can participate without restrictions.
 I have reviewed the program and activities of the camp and feel the camper can participate with the following restrictions or adaptations. (Please describe below.)

Medical Insurance Information:

This camper is covered by family medical/hospital insurance Yes No

Include a copy of your insurance card if appropriate; copy both sides of the card so information is readable.

Insurance Company _____ Policy Number _____
Subscriber _____ Insurance Company Phone Number (_____) _____

Parent/Guardian Authorization for Health Care:

This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

Signature of Custodial Parent/Guardian _____ Date: _____ Relationship to Camper: _____

If for religious or other reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance.

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Camper Name

First

Middle

Last

CLUB ENJOY 2016