Dear Parent/Guardian,

Thank you for selecting the Hamilton College Youth Camps for your child’s summer camp experience. This letter and enclosures pertain to required documentation regarding your child’s health. Please assist our staff by reviewing and completing the Hamilton College Summer Non-Sport Camp Health Record as well as the Medications at Camp form.

**Hamilton Summer Camp Health Record:** Personal Information and Medical History

- In accordance with the New York State Department of Health (NYSDOH), this form must be completed for each child attending camp, with accurate and current information to the best ability of the parent/guardian.
- Only one form needs to be completed if the child is attending multiple camps. Please indicate the camps that your child will be attending on page one of the form.
- A photocopy of your child’s Record of Immunizations may be obtained from your physician and submitted in lieu of completing the immunization section of this form. Please note that the NYSDOH requires an immunization record which includes dates, not simply a note stating that the child’s immunizations are up to date.

No child will be permitted to remain on campus and participate in the camp without this form being complete, which includes a current Record of Immunizations.

**Medications at Camp**

This section of the form must be completed by the camper’s health care provider if your child:

- Needs to take any standard Over the Counter Medication “As Needed” provided by the parent/guardian, while at camp
- Needs to take any routine Prescription Medications, provided by the parent/guardian, while at camp
- Needs to take any Medication “As Needed” provided by the parent/guardian, while at camp
- The NYSDOH and Oneida County Department of Health require that this form be completed prior to the start of camp.
- Completion of this form grants permission to the Camp Health Director and his/her designee(s) to administer prescription and over the counter medication as directed when necessary and supplied by the parent/guardian.

Thank you for taking the time to accurately complete the Personal Information and Medical History Form, as well as the Camp Medication section (if appropriate). Completed forms must be returned at least two weeks prior to your child’s arrival at camp, and should be sent to the following address:

**Hamilton College Non-Sports Camps**  
**Attn:** Dannelle Parker  
**Director, Summer Programs/Conference Services**  
**198 College Hill Road,**  
**Clinton, NY 13323**
Hamilton College Summer Camp (Non-Sports) Health Record

Participation is prohibited without this completed form.

Name ___________________________________ Birth Date __/__/____ Age at Camp _____ Gender: ☐ Male ☐ Female

Address __________________________________ City __________________ State ________ Zip ______

Parent/guardian __________________________________ Home Ph. ____________ Cell Ph. ___________

Address __________________________________ City __________________ State ________ Zip ______
(if different from above)

Other Emergency Contact

__________________________________________________________________________

Relationship ___________________________ Home Phone ________________ Cell Phone ______________

Camps Attending:

☐ Leaders for Life High School Program (overnight)

☐ Leaders for Life Day Camp

☐ Chinese Language Program

☐ Other:________________________________________

INSURANCE INFORMATION

Is the participant covered by family medical/hospital insurance? ☐ Yes ☐ No

If so, indicate carrier or plan name ______________________________________________________________

Policy # ________________________________ Group # ________________________________

Name of family physician __________________________________________ Phone_____________________

Please include a double-sided copy of health insurance card.

IMMUNIZATION:

COMPLETE IMMUNIZATION RECORDS are required for camp attendance. A copy of your child’s Immunization History from your pediatrician may be submitted in lieu of completing the immunization section below.

Please provide all dates of immunization for:

Td or Tdap or DTaP
Tetanus
MMR
or Mumps
or Measles
or Rubella
Polio
Varicella (chicken pox)
Haemophilus Influenza B
Menactra

Date:_____________________________________________________________________________

_____________________________________________________________________________

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_____________________________________________________________________________
**HEALTH HISTORY**

The following information must be completed by the parent/guardian of the camper. The intent of this information is to provide camp health care personnel the background to provide appropriate care. Please keep a copy of the completed form for your records. Any changes to this form should be provided, in writing, to the Medical Director upon participant’s arrival at camp.

A copy of recent physical (within the past 12 months) from your pediatrician may be submitted in lieu of completing the health history section below. School physicals are acceptable.

**GENERAL QUESTIONS:**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>1. Had any recent injury, illness or infectious disease?</td>
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<td>2. Have a chronic or recurring illness/condition?</td>
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<td>3. Ever been hospitalized?</td>
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<td>4. Ever had surgery?</td>
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<td>5. Have frequent headaches?</td>
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<td>6. Ever had a head injury?</td>
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<td>7. Ever been knocked unconscious?</td>
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<td>8. Wear glasses, contacts or protective eye wear?</td>
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<td>9. Ever had frequent ear infections or loss of hearing?</td>
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<td>10. Ever passed out during or after exercise?</td>
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<td>11. Ever been dizzy during or after exercise?</td>
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<td>12. Ever had seizures?</td>
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<td>13. Ever had chest pain during or after exercise?</td>
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<td>14. Ever had high blood pressure?</td>
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<td>15. Ever been diagnosed with a heart murmur/disease?</td>
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<td>16. Ever had back problems?</td>
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<td>17. Ever had problems with joints (e.g. knees, ankles)?</td>
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<td>18. Have any skin problems (e.g. itching rash, acne?)</td>
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<td>19. Have diabetes?</td>
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<td>20. Have asthma?</td>
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<td>21. Use an inhaler?</td>
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<td>22. Had problems with diarrhea/constipation?</td>
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<td>23. Had mononucleosis in the past 12 months?</td>
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<td>24. Have an orthodontic appliance being brought to camp?</td>
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<td>25. Have an absence of a paired organ?</td>
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<td>26. Diagnosed with an emotional disorder?</td>
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<td>27. Diagnosed with a psychiatric disease/disorder?</td>
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Is there any reason why this camper’s activity at camp should be restricted in any way? ____________________________________________________________________________________________

**ALLERGIES:** List all known. Describe reaction and management of the reaction.

Medication allergies (list) ____________________________________________________________________________________________

Food allergies (list) _________________________________________________________________________________________________

Other allergies (list) please include insect stings, hay fever, asthma, animal dander, etc. ________________________________________________________________________________________

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Camp: ____________________________________________

Camper Name: __________________  __________________

DOB: __________________________
PLEASE NOTE:
If your child must take any medication while at camp, either prescription or over the counter, the Medication Section BELOW must be completed as directed. This section must be signed by a physician, and be on file for children requiring medication as part of an established routine, or on an “as needed” or emergency basis.

MEDICATIONS AT CAMP
This section must be completed and signed by the child’s physician/health care provider if your child:
• Needs to take any standard Over the Counter Medications “As Needed” provided by the parent/guardian.
• Needs to take any routine Prescription Medications, provided by the parent/guardian.
• Needs to take any Medications “As Needed” or for emergencies (Epi-Pen, Inhaler, etc), provided by the parent/guardian.

Medications:
YOU MUST PROVIDE THESE MEDICATIONS IN THE ORIGINAL, LABELED CONTAINER.
They will be stored in the infirmary and/or with the Camp Health Director or designee and will be administered as needed, in accordance with the camper’s written health plan (if approved by the by the camper’s healthcare provider). Please complete with the camper’s current regimen for both scheduled and “As Needed” medications (ie. Epi-Pen, Inhaler, etc.).

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Dosage &amp; Schedule</th>
<th>Indications (why needed)</th>
<th>Comments</th>
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Physician Signature: ___________________________________________

Medical Treatment Authorization
In the event of an injury or illness, I give permission for my child ___________________________ to be treated by a qualified athletics trainer, nurse or licensed EMT and/or emergency room staff at the local hospital. I also give permission for medical staff to administer any medications as indicated above. In addition, I consent to have Hamilton College or above service providers use and disclose my child’s protected health information for payment, treatment and health care operations purposes. Protected health information includes medical, billing and demographic information collected and/or created by above service providers. I understand that I will be responsible for all charges for health services by off-campus providers.

Signature of Parent Guardian ___________________________ Date ___________________________

IT IS ADVISED, PRIOR TO MAILING THESE FORMS THAT YOU MAKE A COPY TO HAND CARRY TO REGISTRATION.

NO CAMPER WILL BE ALLOWED TO STAY WITHOUT COMPLETED HEALTH FORMS ON FILE.