FROST VALLEY YMCA GUENTHER FAMILY WELLNESS CENTER
2000 Frost Valley Road, Claryville, NY 12725
TEL 845-985-2291 ext. 225 **FAX** 845-985-0059 **WEB** frostvalley.org

SCHOOL REPRESENTATIVE HEALTH FORM

(Teachers, Administrators, Chaperones and Parents)

School_____**Lead Teacher** _____

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):

___Asthma	___Glasses/contact lenses	___Heart disease/defect
___Diabetes	___Eating disorders	___Nose bleeds
___Hypertension	___Respiratory disorder	___Ear infections
___Seizure disorder	___Sleep walking	___Chicken pox
___Headaches		___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, fundraising 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 _____

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STUDENT HEALTH FORM

DATE OF TRIP: FROM _____ TO _____
School _____ Lead Teacher _____

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):

___Asthma	___Glasses/contact lenses	___Heart disease/defect
___Diabetes	___Eating disorders	___Nose bleeds
___Hypertension	___Respiratory disorder	___Ear infections
___Seizure disorder	___Sleep walking	___Chicken pox
___Headaches	___Bedwetting	___Other

Comments: _____
_____
_____
_____
Any known allergies (Food or Drug): _____
Diet Restrictions _____
Date of Last Tetanus Shot _____

CUT WHEN NEEDED

Note: 2 signatures REQURIED* 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 liscensed 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

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Parent/Legal Guardian's Signature _____ **Date** _____

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WRITTEN PHYSICIAN & PARENT PERMISSION FORM

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

Student 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: <u>All medications must be sent in original packaging.</u>

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	Yes or No
Cough drops	By mouth	Q 2h as needed for sore throat	Yes or No
Robitussin (Guaifenesin)	By mouth (syrup)	Q 4h for cough	Yes or No
Dimenhydrinate	By mouth (chewable tabs 50 mg)	Q 6h motion sickness	Yes or No
Benadryl (Diphenhydramine)	(Beyli xmiro, ucthhe wable tabs or pills)	Q 6h 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 4h for signs of irritation to skin	Yes or No
Hydrocortisone Cream 1%	Apply topically	Q 4h 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 regimen 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

<u>Self-carry medication release for sun block, rescue inhalers, epi-pens and insulin pumps</u>

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

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.

<u>MUST HAVE THE FOLLOWING SIGNATURE</u> 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:_____

LICENSE # STAMP