DATE

BADGER SPORTS CLUB

Health Information

INSTRUCTIONS

PLEASE PRINT. FILL OUT AS COMPLETELY AS POSSIBLE.

M F

NAME OF CHILD

TWO RELATIVES OR FRIENDS WHO CAN BE CONTACTED IN CASE OF EMERGENCY

NAME PHONE

NAME PHONE

EMERGENCY DROP OFF LOCATION

NAME PHONE

NAME OF INNOCULATION	1	2	3	4	5
DTAP / DTP					
POLIO (IPV / DPV)					
HIB					
MMR (Measles, Mumps & Rubella)					
HEPATITIS					
CHICKEN POX					
OTHER					

*** PLEASE NOTE MMR NOT GIVEN AS A COMBINATION VACCINE**

YES NO Are there any allergies?

YES NO Is medication regularly taken?

YES NO Are there any conditions requiring special attention by the camp

YES NO Is there a special diet required?

YES NO Are there any vision or hearing problems?

YES NO Chicken Pox Date

Tetanus Shots Date of most recent

TEETH CONDITION NAME OF DENTIST

SIGNATURE OF PARENT OR GUARDIAN DATE

BADGER CAMP MEDICATION POLICY AS DIRECTED BY N.Y.S.

THE PARENT MUST MAKE A WRITTEN REQUEST FOR ADMINISTRATION OF THE MEDICATION

THE PRESCRIBING PHYSICIAN MUST ALSO MAKE A WRITTEN REQUEST STATING THE NAME OF THE MEDICATION, DOSAGE, AND THE TIME TO BE GIVEN.

THE MEDICATION MUST BE BROUGHT TO THE HEAKTH OFFICE BY THE PARENT IN THE ORIGINAL CONTAINER FROM THE PHARMACY

THIS POLICY APPLIES TO EVEN THE OCCASIONAL REQUEST FOR TYLENOL OR NON PRESCRIPTION MEDICATIONS. ALL MEDICATIONS WILL BE KEPT IN THE OFFICE AND DISPENSED UNDER SUPERVISION. PLEASE SEND A MEASURING SPOON OR CUP WITH THE MEDICATION, IF NEEDED.

PHYSICIANS NAME

ADDRESS (STAMP MAY BE USED)

PHONE

BADGER SPORTS CLUB
119 Rockland Avenue
Larchmont, New York 10538
914.834.1084
www.badgersportsclub.com

The health history heretofore given is correct so far as I know and my child above named has permission to engage in all of the camp activities except as noted. In the event that I of the physician named cannot be reached in an emergency situation, I hereby give permission to the physician selected by Badger Sports Club to hospitalize, secure proper treatment for, and t to order injection, anesthesia or surgery for my child as may be required under such emergency situation.

DATE

BADGER SPORTS CLUB

Parent and Physician authorization for administration of medication in Camp

A. To be completed by the parent or guardian:

I request that my child _____ DOB _____ receive the medication as prescribed below by our physician.

_____

Signature (Parent or Guardian)

_____

Telephone: Home Work Date

B. To be completed physician

I request that my patient, as listed above, receive the following medication:

_____

Medication:

_____

Diagnosis:

_____

Dosage and Route of Medication

_____

Frequency/Time to be given:

_____

If prn, for what symptoms

_____

Desired Action

_____

Possible Side Effects

_____

Duration of Treatment

_____ _____

Physicians Signature Date

_____ _____

Physician's Name (print) Phone

_____ _____

C. Nurse's Signature (To be signed by Camp Nurse) Date

Badger Sports Club

Allergy Action Plan

PLACE CHILDS PICTURE HERE

Step 1: Treatment

		Give Checked Medication (To be determined by physician authorizing treatment)	
If a food allergen has been ingested, but *no symptoms*		☐ **Epinephrine**	☐ **Antihistamine**
Mouth	**itching, tingling, or swelling of lips, tongue, mouth**	☐ **Epinephrine**	☐ **Antihistamine**
Skin	**Hive, itchy rash, swelling of the face or extremities**	☐ **Epinephrine**	☐ **Antihistamine**
Gut	**Nausea, abdominal cramps, vomiting, diarrhea**	☐ **Epinephrine**	☐ **Antihistamine**
Throat*	**Tightening of throat, hoarseness, hacking cough**	☐ **Epinephrine**	☐ **Antihistamine**
Lung*	**Shortness of breath, repetitive coughing, wheezing**	☐ **Epinephrine**	☐ **Antihistamine**
Heart*	**Weak or thready pulse, low blood pressure, fainting, pale, blueness**	☐ **Epinephrine**	☐ **Antihistamine**
Other *		☐ **Epinephrine**	☐ **Antihistamine**
If reaction is progressing (Several of the above areas affected), give:		☐ **Epinephrine**	☐ **Antihistamine**

*** Potentially life-threatening. The severity of symptoms can quickly change**

Dosage

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject® 0.3 mg Twinject® 0.15 mg

Antihistamine: give _____ medication/dose/route

Other: give _____ medication/dose/route

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

Step 2: Emergency Calls

1. Call 911 (or rescue squad: _____) State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Dr. _____ **Phone Number** _____

3. Parent _____ **Phone Number(s)** _____

4. Emergency Contacts **Phone Number(s)**

a _____ **1** _____ **2** _____

b _____ **1** _____ **2** _____

Even if parent/guardian cannot be reached, do not hesitate to medicate or take child to medical facility

SIGNATURE OF PARENT OR GUARDIAN DATE

DOCTOR'S SIGNATURE (REQUIRED) DATE