

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 HEALTH 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 or 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 to order injection, anesthesia or surgery for my child as may be required under such emergency situation.



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

# General Health

Check "Yes" or "No" for each statement.

Explain "Yes" answers below.

Ever been hospitalized?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Ever had surgery?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Have recurrent/chronic illnesses?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Had a recent infectious disease?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Had a recent injury?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Had asthma/wheezing/shortness of breath?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Have diabetes?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Had seizures?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Had headaches?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Wear glasses, contacts, or protective eyewear?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Had fainting or dizziness?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Passed out/had chest pain during exercise?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Had mononucleosis ("mono") during the past 12 months?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
If female, have problems with periods/menstruation?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Have problems with falling asleep/sleepwalking?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Ever had back/joint problems?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Have a history of bedwetting?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Have problems with diarrhea/constipation?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Have any skin problems?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Traveled outside the country in the past 9 months?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

---

---

---

---

---

---

---

---

Mental, Emotional, and Social Health: Check "Yes" or "No"

Explain "Yes" answers below.

*Has the camper:*

*The camp may contact you for additional information.*

Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Ever been treated for emotional or behavioral difficulties or an eating disorder?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
During the past 12 months, seen a professional to address mental/emotional health concerns?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Had a significant life event that continues to affect the camper's life? <i>(history of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)</i>	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

---

---

---

---

---



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