DIRECTORS
Minna & Fred Moskowitz

WINTER ADDRESS
Camp Westmont
2116 Merrick Ave.
Suite 3005
Merrick, NY 11566

Phone: (516) 771-3660
(516) 771-3661
Fax: (516) 771-2654

Wayne County
Poyntelle, PA 18454
Phone 570-448-2500
Fax 570-448-2063

INSTRUCTIONS FOR COMPLETING YOUR MEDICAL FORMS

Please read carefully

Camp Westmont requires that medical forms be received by the camp office a minimum of 30 days prior to attendance at camp. In order to comply with medical insurance guidelines relating to annual physicals, we recommend you call your doctors office **NOW** and schedule an appointment for your child's camp physical.

Mail medical forms no later than May 20th to:

Camp Westmont

2116 Merrick Avenue

Suite 3005

Merrick, New York 11566

In order to comply with the American Camping Association and our insurance company we need you to return these forms as soon as possible.

If you have any questions, please call us at (516) 771-3660 or (516) 771-3661. Thank you.

INSURANCE INFORMATION - TO BE COMPLETED BY PARENT

Camper Name: ______________________________

Medical Insurance Information:

Name of Insurance Company ______________________________

Address ______________________________

Group Number ______________________________

Policy Number ______________________________

Drug Insurance Information

Name of Insurance Company ______________________________

Address ______________________________

Group Number ______________________________

Policy Number ______________________________

Please note that we need you to attach to the medical form a copy of your insurance/drug card. We will need this information in the

Attach a copy of the Insurance card here:

Front:

Back:

Attach a copy of the Drug Card here:

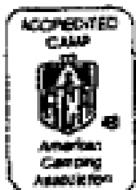
Front:

Back:

IMPORTANT

PLEASE COMPLETE ALTERNATIVE PAYMENT AUTHORIZATION FORM ON REVERSE OF THIS PAGE

Office Use Only: Rec'd ___/___/___ Keyed in ☐ ___/___/___ Copied ☐ ☐ File ☐



CAMP WESTMONT

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Poyntelle, PA 18454
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In the event that the pharmacy/doctor does not accept my medical/drug card, I hereby authorize Camp Westmont to use the following credit card for the purposes of paying for such changes.

Name on card:_______________________________________

Type of card: Visa/Master Card Discover (circle One)

Card Number:_____________________________**Exp. Date:**_________

Card Holder's Signature:______________________ **Date:**__________

Mother's Name: __________________ Father's Name: ___________________

Address: ____

Home Number: ____

Work Number: ____

Cell Number: ____

Alternate Contact: ____

Cell #: ____________________ Phone #: ___________________________

Camper's Birthdate: ____

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MEDICAL HISTORY - TO BE COMPLETED BY PARENT

CAMPER NAME: ______________________

ALLERGIES - List all known. Describe reaction and management of the reaction

Medication allergies (list)

____

____

____

Food allergies (list)

____

____

____

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

____

____

____

Activity Restrictions (if any) ______________________

MEDICATIONS TO BE TAKEN

Please list ALL medications (including over-the-counter or nonprescription drugs). Camp Westmont is now participating in the Camp Meds Program. Parents should contact the Camp Meds Program directly to order medications taken during the summer. Please list any medications being stopped for the summer.

☐ My child takes NO medications on a routine basis.

☐ My child takes medications as follows:

Med # 1 ______________ Dosage ______ Specific times taken each day ______

Reason for taking ______________________

Med # 2 ______________ Dosage ______ Specific times taken each day ______

Reason for taking ______________________

Med # 3 ______________ Dosage ______ Specific times taken each day ______

Reason for taking ______________________

Attach additional pages for more medications.

Identify any medications taken during the school year that participant does/may not take during the summer.

____

Use this space to provide any additional information about the camper's behavior and physical, emotional, or mental health about which the camp should be aware.

____

____

____

____

PARENT'S AUTHORIZATION: This health history is correct as far as I know, and my child herein described has permission to engage in all camp activities except as noted. I agree to the release of any records necessary for treatment, referral, billing or insurance purposes. I hereby give permission to Camp Westmont to provide routine health care, administer prescribed medications and seek emergency medical treatment including taking my child to any hospital facility or outside doctor when deemed necessary. Furthermore, I hereby give permission to such hospital or outside doctor to authorize x-rays and emergency treatment if deemed necessary. I understand that all medical bills for services rendered by anyone other than camp's medical staff are my responsibility.

Signature of Parent: ______________________

Printed Name: ______________________ **Date:** ______________

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MEDICAL EXAM - TO BE COMPLETED BY PHYSICIAN

I examined ______________________________ date ______________
(name) (date)

HT __________ WT __________ HR __________ RR __________ BP __________

HEENT ______________________________

LUNGS ______________________________ HEART ______________________________

ABDOMEN __________ EXT __________ NEURO __________

Which of the following has the camper had?

- ☐ Measles
- ☐ Chicken Pox
- ☐ German measles
- ☐ Mumps
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ TB Mantoux Test

Date of last test __________

Result: ☐ Positive ☐ Negative

Please give all dates of immunization for:

Vaccine: Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP						
TD (tetanus/diphtheria)						
Tetanus						
Polio						
MMR						
or Measles						
or Mumps						
or Rubella						
Haemphilus Influenza B						
Hepatitis B						
Varicella (chicken pox)						

In my opinion, the above child ☐ is ☐ is not able to participate in an active camp program

The child is under the care of a physician for the following conditions:

____

____

Recommendations and Restrictions at Camp

Treatment to be continued at camp

____

Medications to be administered at camp (name, dosage, frequency)

____

Treatment to be continued at camp

____

Any dietary restrictions

____

Known allergies

____

Description of any limitation or restriction on camp activities

____

Additional information for health care staff at the camp

____

Signature of Licensed Medical Personnel: ______________________________

Printed ______________________________ Title __________

Address ______________________________ Phone# __________

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