



HOUGHTON COLLEGE  
&  
CSEHY SUMMER SCHOOL OF MUSIC  
MEDICAL RECORD & WAIVER FORMS



COMPLETION AND RETURN OF THIS FORM TO THE CAMP DIRECTORS IS REQUIRED FOR ADMISSION TO CAMP.

Either Mail This Completed Form Prior To Camp Or Bring It With You To Registration.

\_\_\_\_\_  
Participant's Last Name (print)                      First Name                      Middle Initial

\_\_\_\_\_  
Parent's Last Name                      First Name                      Middle Initial

\_\_\_\_\_  
Home Address (Number & Street), City or Town, State, Zip Code

\_\_\_\_\_  
Home Telephone Number

\_\_\_\_\_  
Business/Cell Number

\_\_\_\_\_  
Camper's Age / Camper's DOB

Your health insurance may be necessary for medical purposes. **Please include a photo copy of the front and back of your medical insurance card.** If you do not have health insurance please fill out the waiver below.

**No Health Insurance Waiver-** I do **NOT** have health insurance; therefore, I am signing this waiver taking full responsibility for all medical matters regarding my child.

- I, \_\_\_\_\_, (parent or legal guardian) take full responsibility for any expenses related to my child's health, be it hospitalization, medicine, or any other cost related to injury or illness, while my child attends camp at Houghton College.
- Furthermore, I do NOT hold Houghton College or Csehy Summer School of Music responsible and/or liable for any and all costs relating to my child's health care for any reason during his/her stay at Houghton College.
- My child's name: \_\_\_\_\_
- Parent signature: \_\_\_\_\_

## IMMUNIZATION RECORD

New York State Department of Health requires the following information, with exact dates, to be completed prior to admittance to camp.

- |   | <u>DATE</u> |
|---|-------------|
| 1. DTP Series completed on                          |             |
| 2. Polio (IPV or OPV) Series completed on           |             |
| 3. TD (Diphtheria/Tetanus)                          |             |
| <b><u>Must have had Booster within 10 years</u></b> |             |
| 4. Measles Vaccine*                                 |             |
| 5. Mumps Vaccine*                                   |             |
| 6. Rubella Vaccine*                                 |             |
| *OR Combined as MMR                                 |             |
| 7. Other  |             |
- If your child has not been immunized please fill out the waiver below.

### No Childhood Immunizations

- I have not immunized my child due to my specific religious beliefs. Therefore, I am signing this waiver taking full responsibility for all medical matters regarding my child that may result from not having the specified shots.
- Furthermore, I do NOT hold Houghton College Or Csehy Summer School of Music responsible and/or liable for any health care needs that may arise due to the absence of specified immunizations during his/her stay at Houghton College.
  
- My child's name: \_\_\_\_\_
  
- Parent signature: \_\_\_\_\_

### MEDICAL RECORD

Are There Any Abnormalities In The Following Areas?

- |                         | No    | Yes   |                        | No    | Yes   |
|-------------------------|-------|-------|------------------------|-------|-------|
| 1. Ears, Nose or Throat | _____ | _____ | 7. Metabolic/Endocrine | _____ | _____ |
| 2. Respiratory          | _____ | _____ | 8. Allergies           | _____ | _____ |
| 3. Cardiovascular       | _____ | _____ | 9. Neuro-Psychiatric   | _____ | _____ |
| 4. Hernia               | _____ | _____ | 10. Eyes (glasses)     | _____ | _____ |
| 5. Gastrointestinal     | _____ | _____ | 11. Genito-Urinary     | _____ | _____ |
| 6. Skin                 | _____ | _____ | 12. Musculo-Skeletal   | _____ | _____ |

1. Have You Suffered Any Major Illness, Injury, Or Disability In The Past? Explain.
2. Have You Had Any History Of Anxiety Or Other Tension States, Eating Disorders Or Emotional Instability?
3. Are You *Currently* Under Treatment For Any Illness, Injury Or Emotional Disturbance? Specify:
4. Have You Any Known DRUG, INSECT, FOOD, or ENVIRONMENTAL Allergies? Please Specify.
5. Do You Carry An Epi-Pen?                      Yes \_\_\_\_\_                      No \_\_\_\_\_
6. Do You Carry An Inhaler?                      Yes \_\_\_\_\_                      No \_\_\_\_\_

Name of Dr.: \_\_\_\_\_

Dr.'s Address: \_\_\_\_\_

Dr.'s Phone Number: \_\_\_\_\_

**THESE WAIVERS MUST BE READ AND COMPLETED PRIOR TO CAMP REGISTRATION**

**PERMISSION TO TREAT**

I give my permission for the directors of the Houghton College Summer Youth Camps and/or Csehy Summer School of Music to provide medical coverage for:

\_\_\_\_\_. If I cannot be reached, in the case of an emergency, I hereby grant permission to the physician selected by the directors to hospitalize, secure proper treatment for, and to order injection, anesthesia, surgery or other treatment as needed for the above mentioned camper. I have consulted with our physician to ensure that the person described here is fit to participate in physically intense activity. They have permission to engage in all program activities, except as noted.

Parent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PERMISSION TO PARTICIPATE FORM**

In consideration of being allowed to participate in the activities and programs of Houghton College and Csehy Summer School of Music, and to use its facilities and equipment, I do hereby waive, release and forever discharge Houghton College and/or Csehy Summer School of Music, their officers, agents, employees, representatives, executors, and all others acting on their behalf from any and all responsibility or liability for injuries or damages resulting from my participation in any activities or my use of equipment in the above mentioned facilities.

It is the desire of Houghton College and Csehy Summer School of Music to provide an atmosphere that is both safe for the campers and secure for their personal belongings. Houghton College provides keys to all dorm rooms for a \$25.00 refundable deposit. Campers are responsible for making sure that their rooms are locked at all times. Campers are not allowed in anyone else's room unless that person is present in the room. Neither Houghton College nor Csehy Summer School of Music assumes any responsibility for loss or theft of any personal items. We also reserve the right to inspect or search any room or its contents at our discretion without the permission of its occupants.

I also grant permission for photographs of my child to be used in the promotion of Houghton College or Csehy Summer School of Music, unless otherwise noted.

Camper Name: \_\_\_\_\_

Parent/Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**TRAVEL PERMISSION SLIP**

In certain situations, it may be necessary for the Houghton College Camps or Csehy Summer School of Music to transport your child to alternate sites. Although your child will be transported on buses by qualified and experienced bus drivers, travel in motor vehicles on public roads always poses the possibility of risk. By signing this slip you are acknowledging that risk and granting permission to Houghton College and Csehy Summer School of Music Camp Directors to transport your child to one of these alternate locations. Please sign and mail this form to us ahead of time or bring with you to registration.

Camper Name: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## MEDICATION INFORMATION

New York State Health Department has specific regulations that impact those children who will need to take prescription or non-prescription medications while here at camp. If your child is on a prescription medication or you expect that your child might need non-prescription ("over the counter") medications, you will need to fill out the medication administration form and have your child bring it to camp. The New York State Health Department is now requiring that all campers needing medications have a physician's script or standing orders with all medications, including "over the counter" varieties.

Medications (prescription and non-prescription drugs) must be in the original container and labeled with the patient's full name, the date the prescription was filled, expiration date, direction for use, precautions (if any), storage requirements (if any), dispensing pharmacy (name and address), and name of physician prescribing medication.

A doctor's standing order/written prescription must come with each prescription medication. The pharmacy script label on the original bottle does not replace the standing order. An individual medication order signed by a physician or other medical provider (physician's assistant, nurse practitioner, dentist, etc.) is required for nurses to administer medications (OTC and Prescriptions). Orders confirm that a medication is current and there has been no change in medication or dosage from that which was originally prescribed (listed on prescription container).

Over the counter drugs (Tylenol, ibuprofen, etc.) cannot be given to children without a standing order/prescription from a physician (including authorization and instructions for use). Please do not bring any over the counter medications with you to camp that are listed on the physician's written order form. These medications will be provided by the camp if it is determined that they are needed. Parental permission by itself is not sufficient for a nurse to administer or a child to self-administer OTC medications. A physician's signature is still required by the New York State Health Department for a child to receive OTC medications. Any OTC medications not listed on the physician's order form should be labeled with the complete name of the camper and stored in the camp's infirmary.

Individuals that may need emergency medications should carry the medications themselves (epi-pens, inhalers). When necessary, staff may be assigned to carry the medication; however, care must be taken to ensure that the patient and medication remain in close proximity to facilitate immediate administration.

A Medication Administration form for your physician to fill out for prescription and "over the counter" medications is included for your convenience. Please fill it out, have your doctor sign it and have your child bring it with them to registration for our camps. No medications will be able to be administered without this form.

### Physician's Written Orders for Prescription Medications

| Students Full Name | Drug Name | Route | Dosage | Schedule & Indications | Comments | Physician's Signature |
|--------------------|-----------|-------|--------|------------------------|----------|-----------------------|
|                    |           |       |        |                        |          |                       |
|                    |           |       |        |                        |          |                       |
|                    |           |       |        |                        |          |                       |
|                    |           |       |        |                        |          |                       |

### Physician's Written Orders for Non-Prescription Medications

| Students Full Name | Drug Name                  | Route<br>Please circle Preferred Formulation | Dosage                                  | Schedule & Indications              | Camper Health Care Provider Order | Comments | Physician's Signature |
|--------------------|----------------------------|--|---|-------------------------------------|-----------------------------------|----------|-----------------------|
|                    | Tylenol                    | PO<br>(chewable tabs, elixir or tabs)        | Per label<br>Instructions by age/weight | Q 4 hr. prn for pain or fever > __F | Yes<br>NO                         |          |                       |
|                    | Ibuprofen                  | PO<br>(chewable tabs, elixir or tabs)        | Per label<br>Instructions by age/weight | Q 4 hr. prn for pain or fever > __F | Yes<br>NO                         |          |                       |
|                    | Robitussin                 | PO<br>(syrup)                                | Per label<br>Instructions by age/weight | Q 4 hr. prn for cough               | Yes<br>NO                         |          |                       |
|                    | Pepto-Bismol               | PO<br>(liquid, or chewable tabs)             | Per label<br>Instructions by age/weight | Q 30 min. -1 hr. prn for diarrhea   | Yes<br>NO                         |          |                       |
|                    | Benadryl                   | PO<br>(elixir, chewable tabs, or pills)      | Per label<br>Instructions by age/weight | Q 6hr. prn for allergic reaction    | Yes<br>NO                         |          |                       |
|                    | Triple Antibiotic Ointment | Topical                                      | Per label<br>Instructions               |                                     | Yes<br>NO                         |          |                       |
|                    | Hydrocortisone Cream 1%    | Topical                                      | Per label<br>Instructions               |                                     | Yes<br>NO                         |          |                       |
|                    | Other                      | PO   | Per label<br>Instructions by age/weight |                                     | Yes<br>NO                         |          |                       |
|                    | Other                      | PO   | Per label<br>Instructions by age/weight |                                     | Yes<br>NO                         |          |                       |