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

This form must be filled out and signed in two places where indicated below

STUDENT HEALTH FORM

DATE OF TRIP: FROM 9/25/19 TO 9/27/19
School Eisenhower Middle School Lead Teacher Mr. Douglas Finale (Team Two Leader)

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) Eisenhower Middle School
(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. I agree to the release of any records necessary for medical treatment or insurance purposes. This authorization shall remain effective until (day after the last day of the trip) 9/28/19 unless sooner revoked in writing delivered by said agent(s).

X ***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. This document may be photocopied.

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

STUDENT MODEL AND STATEMENT RELEASE

Periodically, Frost Valley YMCA uses photos and statements made by participants in 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.

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

This form must be filled out and signed by a parent and physician

Frost Valley YMCA Guenther Family Wellness Center

Written Physician & Parent Permission Form

2000 Frost Valley Road, Claryville, NY 12725 **Tel:** 845.985.2291 **Fax:** 845.985.0059

STUDENT NAME: _____ **DATE OF BIRTH:** _____

SCHOOL NAME: _____

PHYSICIAN'S NAME: _____ **PHONE:** _____

The following overy they counter medications are available at the Wellness Center, and can be administered as needed per label instructions by age and weight of the student. **PLEASE NOTE:** Absolutely **NO** overy they counter or prescription medications, supplements, vitamins, or topical ointments can be administered without a physician and parent's signature , in accordance with New York State Education Law, Title 139, Section 6902.

ALL MEDICATIONS SENT TO CAMP MUST BE SENT IN THEIR ORIGINAL CONTAINERS WITH LABELING INTACT

TO THE PROVIDER: Please, indicate approval for administration by circling yes or no in the space indicated.

MEDICATION	ROUTE	DOSAGE	SCHEDULE & INDICATIONS	MAY BE ADMINISTERED
Tylenol (Acetaminophen)	By mouth (elixir or tablets)	Per label instructions By age and weight	Every 4 hours PRN pain or fever > _____°F	Yes No
Motrin (Ibuprofen)	By mouth (elixir, suspension or tablets)	Per label instructions By age and weight	Every 4 hours PRN pain or fever > _____°F	Yes No
Phenylephrine HCl	By mouth (tablets)	Per label instructions By age and weight	Every 4 hours PRN nasal congestion	Yes No
Robitussin (Guaifenesin)	By mouth (syrup)	Per label instructions	Every 4 hours PRN cough	Yes No
Dramamine (Dimenhydrinate)	By mouth (chewable tabs or tablets)	Per label instructions By age and weight	Every 6 hours PRN motion sickness	Yes No
Benadryl (Diphenhydramine)	By mouth (elixir, tablets or capsules) Apply topically	Per label instructions By age and weight	Every 6 hours PRN allergies, or insect bites	Yes No
Claritin (Loratadine)	By mouth (tablets)	10 mg	Daily PRN allergy symptoms	Yes No
Zyrtec (Cetirizine HCl)	By mouth (tablets)	10 mg	Daily PRN allergy symptoms	Yes No
Allegra (Fexofenadine)	By mouth (tablets)	180 mg	Daily PRN allergy symptoms	Yes No
Tums (Calcium Carbonate)	By mouth (tablets)	840 mg	Every 2 hours PRN acid indigestion	Yes No
Imodium	By mouth (tabs or capsules)	Per label instructions	After loose stools	Yes No
Lactaid (Lactase)	By mouth (caplets)	Three caplets	With first bite of dairy	Yes No
Maalox	By mouth (suspension)	10 mL	Every 4 hours PRN upset stomach	Yes No
Sunblock or Sunscreen	Apply topically	SPF ≥30	Apply PRN prior to sun exposure	Yes No
Insect Repellant	Apply topically	Aerosol or pump	Per label instructions	Yes No
Bacitracin Ointment	Apply topically	Bacitracin Zinc 500 U	Apply 1-3x Daily PRN minor cuts	Yes No
Hydrocortisone Cream 1%	Apply topically	Hydrocortisone 1%	Apply 3-4x Daily PRN skin irritation	Yes No
Antifungal Cream	Apply topically	Tolnaftate 1%	Apply twice daily to soothe itching	Yes No
Calamine Lotion	Apply topically	Per label instructions	As needed PRN itching	Yes No

PROVIDER: Please document below the current medication regimen for the above-stated student, including scheduled and PRN medications.

MEDICATION	ROUTE	DOSAGE	SCHEDULE	COMMENTS

The above-stated student may self-carry the following items and/or medications (select all that apply):

❑ Sunblock ❑ Epi-Pen ❑ Albuterol Inhaler ❑ Proventil Inhaler ❑ Insulin Pump Pens ❑ Other: _____

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 acknowledges the proper understanding of the purpose, frequency, and appropriate method of use of these items and/or medications. 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 and/or medications.

Physician/Healthcare Provider Signature: _____

LICENSE# STAMP

Parent/Guardian Signature: _____ **Date:** _____