Return All Forms To: Administrative Address
985 Livingston Avenue
North Brunswick, NJ 08902
Direct Phone/Fax: 732-737-8279
Email to: medical@campjaycee.org

Dear Parent/Guardian,

Camp Jaycee requires that all campers have an annual physical completed by a licensed professional healthcare provider. We are excited to now offer express check in to all of our camp participants and have partnered with Genoa Health Care Company to stream line this process. Genoa Health Care Company is a full-service pharmacy who specialize in serving individuals living with disabilities. An assigned Genoa pharmacist and technician team will work with you and your health care provider(s) to have your campers prescriptions filled for their stay at camp. Genoa will bill your insurance carrier and accepts ALL plans including Medicaid/Medicare. Genoa will package and ship all medications to camp prior to the camper's arrival. The process is simple and is at no cost to you, please read the Genoa Pharmacy Information included with your packet.

We are committed to the health and safety of our campers and staff, and ensure that this partnership is the safest option to reduce medication errors and will significantly reduce your wait time at check in. Additional information and enrollments forms for Genoa's pharmacy are enclosed in this packet, Genoa will work directly with you to ensure that all of the camp participant's medications are accurately filled and delivered to Camp Jaycee. Please share this information with your camper's health care providers. All prescriptions must be sent to Genoa's pharmacy team one month prior to arriving to camp, this will allow the pharmacy staff to accurately fulfill each order and timely delivery to our nurses. During check in our nursing staff will ONLY perform a minimal health screening to the camper. No more packing medications or sending prescription copies to camp.

Instructions for completing this packet:

1. Page 2 To be completed by the camper's primary caregiver
2. Pages 3-7 must be completed by a licensed professional healthcare provider
3. Page 7- Only medications/ daily vitamins and supplements to be taken while at camp must be listed and signed off by a licensed professional healthcare provider. Please feel free to attach additional pages if needed.
4. Complete the enclosed Genoa enrollment forms
5. Completed medical forms must be mailed to the administrative office 4 weeks prior to the start of date, please make a copy of this packet upon completion of your records.
6. Please have your doctor fax all prescriptions no later than 4 weeks to camp check in, directly to Genoa pharmacy at (201) 450-9000 or (201) 487-1935.

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2019 Physical Examination and Health Assessment

PLEASE NOTE: Camper must have a complete physical examination annually.
Our Administrative Office must receive the physical exam form at least 1 MONTH before camp session starts.

This page should be completed by the primary caregiver/individual that can provide additional health information.

Camper Information				
Last Name			First Name	MI
Gender:	Male	Female	Birth Date: / /	Age During Camp:
Dates Attending:				
Circle Residence:	Family/Relative	Group Home	Independent Living	Other _____
Applicant's Residential Address			Parent / Guardian Address	
Name of Group Manager:			Name of Parent or Guardian:	
Home:	Cell:		Home:	Cell:

Emergency Contacts- Other than Parent or Guardian listed above -Must be Available 24/7 during Program Period	
Name	Name
Relationship	Relationship
Home #	Home #
Work #	Work #
Cell #	Cell #
Address:	Address:

New Jersey Department of Disability - Must be completed if participant receives services from DDD		
DDD ID#	**Medicaid ID#**	**Support Coordination Agency**
Support Coordinator Name		**Phone Number**

TO BE COMPLETED BY LICENSED HEALTHCARE PROVIDER

Medical / Health Information

Applicant's Height:	**Applicant's Weight**:

Please provide patients disability/diagnosis

Has the applicant had a recent illness or injury (circle) Yes No

If yes please explain:

Please indicate the state of the following by circling the appropriate answer.

Diabetes? Yes No *If Yes, please complete the following*:

Is Diabetes under control? Yes No

Type of Diabetes:	Type 1	Type 2	Require glucometer testing?	Yes	No
Require Insulin?	Yes	No	If Yes: frequency of testing:		

**********IMPORTANT ATTACH SEIZURE PLAN IF APPLICABLE**********

History of Seizures? Yes No *If Yes, please complete the following:*

Are seizures under control?	Yes	No	Type of seizure?	
Last Occurrence?			Duration?	

Additional comments or information about seizures that camp should be aware of to best serve camper:

State the current condition of each of the following *(circle the appropriate choice)*:

Skin:	Good	Poor	Lungs:	Good	Poor	Extremities :	Good	Poor
Throat:	Good	Poor	Heart:	Good	Poor	Abdomen:	Good	Poor
Nose:	Good	Poor	Lymph glands:	Good	Poor	Muscular Development:	Good	Poor
Eyes:	Good	Poor	Teeth:	Good	Poor	Ears:	Good	Poor
Wears glasses?	Yes	No	Wears Dentures?	Yes	No	Wears Hearing Aid?	Yes	No
						If Yes, Which Ear(s)?	Right	Left

If Poor, please provide details:

TO BE COMPLETED BY LICENSED HEALTHCARE PROVIDER				
Medical / Health Information Cont'd				
Allergies *(please circle yes or no)*			If Yes, please list **triggers** (allergens)	If Yes, **how is allergy controlled**?
Food	Yes	No		
Seasonal	Yes	No		
Environmental	Yes	No		
Insect Bites/Stings	Yes	No		
Medication	Yes	No		
Other	Yes	No		

Has camper ever required **Immediate medical attention** due to an **allergic reaction**?	Yes	No
If **Yes**, please provide details:		

Does the camper have **Asthma**?	Yes	No	Require the use of a Nebulizer or Asthma Pump?	Yes	No
If **Yes**, please provide details: (Chronic, Exercise Induced, Seasonal Allergy related)?					

Has or is an **Epi Pen** ever been **used by** or **prescribed** for this camper?	Yes	No
If **Yes**, please provide details to administer:		
Are there any **Activity Restrictions** or limitations for this camper?	Yes	No
If Yes, please provide details:		

Diet/Nutrition		
Does the participant eat a regular diet?	Yes	No
Are there any **Dietary Restrictions/Food Allergies** for the camper?	Yes	No
If Yes, please provide details:		

Does camper currently have any of the following:					
Shortness of breath	Yes	No	Fainting spells	Yes	No
Frequent diarrhea	Yes	No	Constipation	Yes	No
Frequent urination	Yes	No	Tonsillitis	Yes	No
Sinus problems	Yes	No	Earaches	Yes	No
If Yes, please provide details					

TO BE COMPLETED BY LICENSED HEALTHCARE PROVIDER			
Medical / Health Information Cont'd			
Does Camper have any **Communicable Diseases**?	Yes	No	
If **YES**, please provide details:			
PLEASE NOTE: Previous TB tests are only valid for up to **five (5**) years prior to **camp start date**.			
Mantoux (PPD) Tuberculin Test:	**Negative**	**Positive**	**Date Read:**
Please complete the following:	Read by:		
Is camper currently free from active TB?	Yes	No	Date of last chest x-ray :
PLEASE NOTE: The CDC recommends the **Hepatitis B series** be completed by all adults attending both residential and non-residential day care facilities for persons with developmental disabilities. **PLEASE NOTE**: The CDC recommends a **Tetanus booster every ten (10) years**. Please be aware that NJ Camp Jaycee is a rustic environment therefore the above is required.			
Are immunization records attached?	Yes	No	*If NO, please complete the following:*
Hepatitis B series completed?	Yes	No	If Yes, date completed
DPT – MMR – Polio completed?	Yes	No	**Date of last Tetanus (dT) or TdaP)** _____ **(Month/Year)**
Physical Examination and Health Assessment is continued on next page.			

Permission to Administer Over the Counter Medications

The following over the counter (OTC) medications are stocked in the camp infirmary and listed as standing orders for the symptom indicated. Personal OTC medication supplies are not needed unless it is taken as a routine mediation. If an OTC is routine, a signed prescription is required.

Condition	Over the Counter Medication(s) administered
Pain / Fever / Menses	Mild pain / fever under 101 – Acetaminophen (Tylenol) Severe pain / fever over 101 – Ibuprofen (Motrin, Advil)
Sore Throat	Acetaminophen (Tylenol) Anesthetic lozenges (Cepacol) – regular and sugar free
Cold Symptoms	Sinus decongestant (Sudafed) Multi-symptom cold relief medications (for cough and cold)
Cough	Guaifenenesin cough suppressant (Robitussin) Cough drops – regular and sugar free
Indigestion / Gas	Antacid / Antigas medications (Tums, Mylanta, Gas X)
Diarrhea	Imodium – but only after 2 watery stools
Constipation	Laxatives / Stool Softeners (Senna, Co-lace, Milk of Magnesia, Ex Lax)
Allergies / Poison Ivy / Rash	Antihistamines (Benadryl) Topical Calamine lotion or Hydrocortisone cream
Beestings / Bug Bites	Sting ease product
Burns	Aloe Vera Lotion, Soloracaine, Silvadene
Cuts / Scratches / Abrasions	Cleanse with peroxide & treat with antibiotic ointment (Neosporin)
Fungal / Jock Itch / Athletes Foot	Antifungal medications (Lotrimin)
Muscle Pain	Mild – athletic rub (Ben Gay) Severe – Ibuprofen (Motrin, Advil)
Earache	Swimmers Ear – Aura Dry Wax Removal – Debrox
Toothache	Anesthetic gel or liquid (Oragel)
Eyes	Allergies – Visine AC Wash – Sterile saline

I hereby grant permission for New Jersey Camp Jaycee to administer the above over the counter medications if the nurse deems necessary. Medication will be administered as either tablets or liquid. Dosages will be administered according to the directions on the bottle unless a physician directs otherwise. All medications may be substituted with generic versions.

Physician Signature (required): **Date:**

Camper's Name:

Medication Record & Physician Certification

***************This forms is to be completed by the PHYSICAN ONLY***************

Instructions for completing the medication record:

- **List all daily medications, over-the counter medications and/or supplements to be administered to participant while at camp.**
- **Physician signature and office stamp is required, this certifies that the physician has conducted the physical and approves all medications to be administered.**

Healthcare providers please send all prescriptions to our partner pharmacy.
Genoa Pharmacy department at: Phone (201) 546-5839/ Fax (201) 450-9000 or (201)487-1935

Routine Medication

- ☐ **This participant will NOT take any daily medications while attending camp.**
- ☐ **This participant will take the following medication(s) while at camp.**

Medication Name	Dosage	Times Administered

I hereby grant permission for the attending camp nurse to follow the above orders for medication.

I certify that on ____/____/____ I examined_____ and reviewed his / her health history. I recommend him / her as a camper in your summer camp.

Physician's Signature:	**Date:**
Physician's Name:	
Address:	**Phone/Fax Numbers:**
	Physician Stamp HERE: (required)

All prescriptions are required to be sent to our partner pharmacy
Genoa Healthcare Phone: (201) 546-5839/ Fax (201)450-9000 or (201)487-1935

New Jersey Camp Jaycee 2019 Authorization to Medical Emergency Care

In the event that I, the Parent/ Guardian, cannot be reached in a medical emergency, I authorize New Jersey Camp Jaycee Staff to act on my behalf to authorize unexpected medical and hospital care for camper (excluding major elective surgery).

Camper Name:	**Camper Social Security Number :**	
Parent/Guardian Name:		
Telephone home:	**work:**	**cell:**
Parent / Guardian Signature:		**Date:**

This document shall be presented to an appropriate hospital representative at such time as unexpected hospital care may be required.

Camper Medical Insurance Information

Failure to supply camper's medical insurance information will result in the camper not being admitted to camp.

Primary Insurance Company:
Primary Policy Number:
Subscriber:
Primary Insurance Phone Number:
Secondary Insurance Company:
Secondary Policy Number:
Secondary Subscriber:
Secondary Insurance Phone Number:

If any of the above items does not apply, please write "N/A" or "does not apply" in the space provided.

PLEASE NOTE: Any hospital or doctor bill incurred will be submitted to your insurance company by the health care provider.
NJ Camp Jaycee does not file medical insurance claims.
Follow-up on insurance claims is the responsibility of the camper's parent / guardian.