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/Health Provider,

The health and safety of our campers is our first concern, we are proud to be able to support the needs of all our campers at our on-camp infirmary, staffed by RNs, LPNs and EMTs. Our nurses are responsible for all medication distribution, including 5 daily medication passes, 8:45, 1:00, 3:45, 6:00 and 8:00. Our nurses dispense all medication directly to our campers. All health concerns are addressed and documented by our medical team. All medical staff work together to provide the best care for our campers and staff. Camp Jaycee requires that all campers have an annual physical completed by a licensed professional healthcare provider. Please carefully read and review this packet with the healthcare provider to ensure it is accurately completed.

Completing this packet:

- Pages 1 and 6 Must be completed by the camper's primary caregiver/group home manager or legal representative
- Pages 2-5 Must be completed by a licensed professional healthcare provider
- Seizure Action Plan - If applicable the Physician must complete enclosed Seizure Action Plan

Medication Procedures

Option #1 Priority Check In

We offer priority check in for campers who would like to have prescriptions fulfilled with our partner pharmacy Genoa Healthcare. This option will significantly reduce your wait time at check in. Genoa will fill, package and deliver to the camp infirmary prior the campers arrival. NOTE: If the camper takes any routine over the counter medications, birth control, supplements, lotions, drops or ointments a signed prescription or doctors note is required to be sent in with the campers physical 1 month before arrival. **Genoa cannot fill these prescriptions.** To request an enrollment form please select New Genoa Enrollment on page 1.

If your camper previously enrolled with Genoa, they do not have to re-enroll, just indicate on your physical form that you would like to use the service again. If there have been any changes with insurance or pharmacy within the last year, please contact the pharmacy team they are available Monday – Friday 8 AM – 5 PM via phone at 201-546-5839.

Option #2 Check in with Medications

We will accept medications in person at the time of check in, this option may have a significant wait time. **SIGNED** electronic prescription record(s), handwritten prescriptions or physician's orders with the prescribing physician's signature recorded on the documents, must be returned in advance with the camp participants completed physical packet. Medications must arrive to check-in in the original standard pharmacy vial or recommended multi dose packaging. NOTE: If the camper takes any routine over the counter medications, supplements, lotions, drops or ointments a signed prescription or doctors note is also required**.** Medical forms and prescription records are due 1 MONTH prior to the start of date.

Attach current SIGNED electronic prescription records (E-Script), handwritten prescriptions or physician's orders with the prescribing physician's signature recorded on the document. Prescriptions including daily over the counter, vitamins and supplements that have been ordered by the physician within 12 months are valid, narcotic prescriptions are valid for 6 months. Please make a copy of this packet upon completion of your records.

2020 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.
Mail all forms to: 985 Livingston Ave., North Brunswick, NJ 08902 or Email to: medical@campjaycee.org.

Please select one option: **_____ Previous Genoa participant _____ New Genoa Enrollment _____ I will check-in w/ medications**	
Campers Last Name	Campers First Name MI
Gender: Male Female	Birth Date: / / Age During Camp:
Dates Attending (circle): WK 1 WK 2 WK3 WK 4 WK 5 WK 6 WK 7 WK 8 DOOR's	
Circle Residence: Family/Relative Group Home Independent Living Other _____	
Camper's Address:	Parent / Legal Guardian Address:
Group Manager Name: Home: Cell:	Name of Parent or Legal Guardian: 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 or Medicaid	
DDD ID# **Medicaid ID#**	**Support Coordination Agency**
Support Coordinator Name	**Phone Number**

TO BE COMPLETED BY LICENSED HEALTHCARE PROVIDER (PAGES 2-6)	
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:	
Are there any Activity Restrictions or physical limitations for this camper? Yes No	
If Yes, please provide details (i.e.: walker, wheelchair):	

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 COMPLETE ATTACHED SEIZURE PLAN IF APPLICABLE*******************

History of Seizures? Yes No *Type of seizure?:*	
Are seizures under control? Yes No	Last Occurrence?

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

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

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		

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 **attach a copy of the current prescription** and provide details to administer:						
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						

PLEASE NOTE: Please be aware that NJ Camp Jaycee is a residential rustic environment therefore the below is highly recommended in accordance with information provided by the CDC.

Does Camper have any **Communicable Diseases**?		Yes		No
If **YES**, please provide details:				
Are immunizations records attached?	**Yes**	**No**	***If NO, please complete the following:***	
Tuberculin Test (PPD): Negative Positive		Date Read:		Read by:
Is camper currently free from active TB?	Yes	No	Date of last chest x-ray :	
Hepatitis B series completed?	Yes	No	If Yes, date completed	
DPT – MMR – Polio completed?	Yes	No	Date of last Tetanus (dT) or TdaP):_____	

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. <u>If an OTC is routine, a signed prescription is required</u>.

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	Guaifenesin 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:

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

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

Instructions for completing the medication record:

1. **List all daily prescribed medications, routine over-the counter medications and/or supplements, Epi-Pen, Diabetic supplies, and Asthma medication/supplies to be administered to participant only while at camp.**
2. **Provide a current original signed copy of the most resent E-Script Report or written prescription for each prescribed medication, including daily vitamins/supplements and over-the counter medications. Attach to form or send to Genoa Pharmacy. * See cover page for more information.**
3. **Physician signature and office stamp is required, this certifies that the physician has conducted the physical and approves all medications to be administered.**

PLEASE NOTE: A signed discontinue order is required for each medication that is no longer given if they are listed below.

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 or License Number HERE: (required)

IMPORTANT: CAMPERS ENROLLED WITH GENOA HEALTHACARE SEND ELECTRONIC PRESCRIPTION REQUEST TO: GENOA HEALTHCARE 25 E. Salem St., Hackensack, NJ 07601 or fax to: 201-487-1935 or ATTACH COPIES OF ORIGINAL SIGNED PRESCRIPTIONS if the camper is checking in with medications.

New Jersey Camp Jaycee 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).

Campers that reside in New Jersey:
As per the state of NJ Law, staff are required to notify guardians or family members within 2 hours of an incident involving injuries that are reportable to the state or any incident and/or suspicions of abuse, neglect or exploitation.

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:
If Applicable please include additional insurance below
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.

Final Check List

Please carefully check that all have been completed.

- ☐ Page 1 Completed by the camper's primary caregiver/group home manager or legal representative.
- ☐ Pages 2-5 Completed by a licensed professional healthcare provider.
- ☐ Page 4-5 signed by the physician.
- ☐ Page 6 Completed by the camper's primary caregiver/group home manager or legal representative.
- ☐ Attached all original prescriptions for medications listed on page 7 (if not enrolling with Genoa).
- ☐ Request Genoa enrollment form (if applicable).
- ☐ E-Mail or mail the complete packet to address on page 2.