Camper/Client Name: _____ Date of Birth: _____

Immunization History: Provide the month and year for each immunization. Starred (*) immunizations must include date to meet ACA standards. Copies of immunization forms from health-care providers or state or local government are acceptable; please attach to this form.

Immunization	Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most Recent Dose Month/Year
Diptheria, tetanus, pertussis (DTap) or (TdaP)						
Tetanus booster* (dT) or (TdaP)						
Mumps, measles, rubella (MMR)						
Polio (IPV)						
Haemophilius influenza type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox) ☐ Had chickenpox Date:						
Meningococcal meningitis (MCV4)						
SARS-COV-2 (COVID-19) Manufacturer:						

Tuberculosis (TB) test	Date:	☐ Negative	☐ Positive

Medication (any substance a person takes to maintain and/or improve their health. This includes vitamins & remedies.)

- ☐ This camper will not take any daily medications while attending camp.
- ☐ This camper will take the following daily medication(s) while at camp:

Please review the instructions about required packaging/containers. Please be sure enough medication is provided to last the entire time the camper/client will be at the camp.

Name of medication	Reason for taking it	When it is given	Amount or dose given	How it is given
		☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time(s): _____		
		☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time(s): _____		
		☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time(s): _____		
		☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time(s): _____		

The following non-prescription medications may be stocked in the camp Health Center and are used on an as needed basis to manage illness and injury.
Cross out those the camper should not be given.

Acetaminophen (Tylenol)
Phenylephrine decongestant (Sudafed PE)
Antihistamine/allergy medicine
Diphenhydramine antihistamine/allergy medicine (Benadryl)
Sore throat spray
Lice shampoo or cream (Nix or Elimite)
Calamine lotion
Laxatives for constipation (Ex-Lax)
Ibuprofen (Advil, Motrin)
Pseudoephedrine decongestant (Sudafed)
Guaifenesin cough syrup (Robitussin)
Dextromethorphan cough syrup (Robitussin DM)
Generic cough drops
Antibiotic cream
Aloe
Bismuth subsalicylate for diarrhea (Kaopectate, Pepto-Bismol)

RISING TREETOPS AT OAKHURST

111 Monmouth Road, Oakhurst, NJ 07755 * Tel. 732 531-0215 * Fax. 732 531-0292

ANNUAL PHYSICAL EXAM 20_____

Camper/Client Name _____ Date of Birth _____

Camper/Client Home Address _____ Height _____ ft _____ in

_____ Weight _____ lbs

Parent/Guardian(s) phone: _____ Blood Pressure _____ / _____

DIAGNOSIS _____

Skin:
Head/Neck/Thyroid:
Nose/Throat:
Eyes/Vision: Corrective Lenses: Yes No
Ears/Hearing: Hearing Aids: Yes No
Dentition: Dentures: Yes No
Neuro/Behavioral: Seizures: Yes No
Cardiac: EKG Abnormalities:
Pulmonary:
Abdomen/GI:
Renal/Urinary:
Shunt Present: Yes No Date of last revision: _____
Back/Spine/Extremities:

DIETARY GUIDELINES/RESTRICTIONS:

FOOD CONSISTENCY: Whole 1"pieces

½" pieces 1/4" pieces Ground

Puree Softened foods

LIQUID CONSISTENCY: Thin Nectar/Syrup

Honey Pudding

ALLERGY HISTORY:

Medications: _____

_____

Foods: _____

_____

Environmental: _____

_____

Other: _____

_____

ADAPTIVE EQUIPMENT/SCHEDULE OF USE:

_____

_____

_____

RESTRICTIONS TO NORMAL ACTIVITY (diet, sun, swimming, sports, etc.): _____

_____

_____

(Print or Stamp)

Physician's Signature _____ Physician's Name _____

Date of Exam _____ Address _____

Phone Number _____ _____

RISING TREETOPS AT OAKHURST MEDICAL CLEARANCE – 20 _____

Rising Treetops at Oakhurst provides overnight respite, after school respite, overnight summer camp and summer day camp services at its campus in Monmouth County, NJ. We serve children and adults with special needs, including autism and physical and intellectual disabilities.

ACCOMODATIONS:

- All cabins and activity areas are wheelchair accessible
- Winterized cabins for use during fall-spring respite season; Window unit air conditioning available over 80° F
- Group living; counselors reside with campers/clients

TERRAIN

- Paved pathways to access all living/activity areas
- Some uneven ground, slight inclines

MEDICAL CARE

- Nursing staff on call during fall-spring season; Nurse on site during summer camp
- Health Center is heated/air conditioned
- The closest hospitals are: Monmouth Medical Center, Long Branch, NJ and Jersey Shore Medical Center, Neptune City, NJ – each approximately 10-15 minutes from the camp.

****

It is my opinion that (Camper's/Client's Name) _____ D.O.B. ____/____/____

☐ **Has no** health condition or concern regarding side effects of currently prescribed medication that requires any activity restriction in our camp setting.

☐ The individual should follow the following Activity Restrictions:

_____

_____

_____

(Print or Stamp)

Physician's Signature _____ Physician's Name _____

Date _____ Address _____

Phone Number _____ _____

RISING TREETOPS AT OAKHURST
111 Monmouth Road, Oakhurst, NJ 07755 * Tel. 732 531-0215 * Fax 732 531-0292

As of June 1, 2023, Rising Treetops at Oakhurst requires that ***all medications be prepared by a pharmacy according to the specific time(s) medication(s) must be administered***. Single dose pill pouches are preferred but we will also accept blister packaging. We encourage you to locate a pharmacy that will work with you, your doctors, and insurance carrier to make sure our requirements are met. Please start the process at your earliest convenience.

Medical Insurance Information:

- ☐ Medicaid: No. _____
- ☐ Medicare: No._____
- ☐ Private Insurance – Insurance Company _____ Policy No. _____

  Subscriber _____ Insurance Co. Phone _____

Include a copy of your insurance card; copy both sides of the card so information is readable.

MEDICAL CONSENT STATEMENT

Parent/Guardian with legal custody to be contacted in case of illness or injury:

Name: _____ Relationship to Camper/Client: _____

Preferred Phones: (_____) _____ (_____) _____

E-mail: _____

Second parent/guardian or other emergency contact:

Name: _____ Relationship to Camper/Client: _____

Preferred Phones: (_____) _____ (_____) _____

Additional contact in the event parent(s)/guardian(s) cannot be reached:

Name: _____ Relationship to Camper/Client: _____

Preferred Phones: (_____) _____ (_____) _____

In case of medical emergency, the person(s) listed above will be notified. However, the Director or an authorized representative is granted permission to arrange for emergency medical treatment should it be required before notification is achieved.

Signature of Adult Applicant, Parent or Guardian _____ Date _____