Joel Ross Tennis Camp
PO Box 62H Scarsdale, NY 10583 after June 20: Kent School PO Box 2006 Kent, CT 06757
914-723-2165 fax 914 723-4579 summer fax 860-927-6039 info@joelrosstennis.com

Form Checklist for Parents:

Please return all applicable forms asap.

No camper may begin camp without completed medical forms.

1- Print all forms below:

- Form Checklist for Parents
- Medical Forms Cover Sheet
- Medical Form
- Non-Prescription Form
- Prescribed Medication Form
- Confidential/Disclosure Statement
- Behavior Contract
- Activity Permission, Camper's E-Mail, Credit Card

2- View forms below & print as needed

- Roommate Request, Logo Order Form, ESL lessons, Linen Rental (all on one page)
- Camp Bus from Bloomingdale's, White Plains

3- View informational forms below

- Clothing/Supplies List
- Important Camp Info
- Directions to Camp
- Pictures of Logo Items
- Sending E-Mail to Campers (Bunknotes)
- Cancellation Insurance

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Medical Forms Cover Sheet

Paper clip/staple forms 1, 2 & 3 together & give the packet to the physician when camper gets his physical exam.

Follow steps 1 thru 5 below:

1. **Medical Form** completed & signed by physician & parent.

2. **Non Prescription Authorization Form** initialed & signed by physician & parent. Physician & parent must initial each permitted medication.

3. **Prescribed Medication Authorization Form** signed by physician & parent. Only send back this form if prescribed medication is to be taken at camp.

4. **Health Insurance Card**: Please attach a front & back copy of the family's health insurance card when returning medical forms to us.

5. **Head Lice:** Please check at doctor's office & right before sending child to camp! We screen campers for head lice upon arrival at camp. Campers with lice will be sent home.

MEDICAL FORM

return before camp begins
Joel Ross Tennis Camp
PO Box 62H Scarsdale, NY 10583

Instructions * Please be sure to complete the PARENT SECTION:
then give this form to your physician.
after June 20: Kent School PO Box 2006 Kent, CT 06757 fax 860-927-6039

PARENT SECTION: *Though the likelihood of an emergency at camp is small, all information noted here must be provided. If details of your child's medical history are unclear, please have the physician assist you in completing both sides of this sheet. Authorizations must be signed to guarantee attendance at camp. Thank you.*

Camper/Staffer Name_____Gender____
Birth date_____Session(s) attending_____

Parent Name (s)_____
Home ph_____Work ph_____
Cell ph_____e-mail/fax_____
Address_____
City_____State_____Zip_____

If two household family...Parent Name_____
Home ph_____Work ph_____
Cell ph_____e-mail/fax_____
Address_____
City_____State_____Zip_____

Emergency Contact. If parent/guardian isn't available, please notify:
Name_____Relationship_____
Phone #'s (work, home & cell)_____
Address_____
City_____State_____Zip_____

Name of child's physician_____
Phone_____
**Please attach address/phone of all specialists caring for your child*

Do you carry family medical/hospital insurance? Yes___ No___
If so, carrier or plan name_____Group #_____
Carrier address_____
Name of insured (parent/guardian)_____

Parent Authorizations * The health history below is correct as far as I know, and the person herein described has permission to engage in all camp activities except as noted...I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, treatment, to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me/or my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer hospitalization, injections, anaesthesia, surgery, and/or any other proper treatment for the person named above...This form may be copied for trips out of camp.

PARENT SIGNATURE_____Date_____

Health History to be completed by Parent * *the intent of this information is to provide camp health care personnel and counselors the background to provide appropriate ongoing and emergency care. In completing this form it is assumed that the camp directors will be provided with any and all updated medical information right up to the first day of camp.*

Medications (including vitamins) taken routinely. * *if additional meds, note on attached page.*

Medication #1_____
Dosage_____How often each day_____
Reasons for taking:

Medication #2_____
Dosage_____How often each day_____
Reasons for taking:

This person takes NO medications on a routine basis_____

Allergies * *Please describe reaction and management of reaction. Use additional page if necessary.*

Allergies to medications, and reaction:

Allergies to food, and reaction:

Other allergies (insect stings, hay fever, asthma, animals, etc.)

PARENT * Please see other side for more required information

PARENT SECTION Continued...

Camper/Staffer Name_____

Restrictions * *Please discuss these in detail on an attached page.*

Dietary:

Physical activity to be restricted:

Contagious diseases Date

___Measles _____
___Chicken Pox _____
___German Measles _____
___Mumps _____
___Hepatitis _____

Additional Information - *about the participant's physical or mental health about which we should be aware - can be provided below or on an attached page.*

General Questions i.e. 'you' refers to child	Yes	No
1. Have you ever been hospitalized?	___	__
2. Have you ever had surgery?	___	__
3. Have you any chronic or recurring illness/condition?	__	__
4. Have you had mononucleosis in the past 12 months?	__	__
5. Have you ever passed out during/after exercise?	___	__
6. Have you ever been dizzy during/after exercise?	___	__
7. Have you ever had chest pain during /after exercise?	__	__
8. Have you ever had high blood pressure?	___	__
9. Have you ever been told you have a heart murmur?	___	___
10. Have you ever had a head injury?	___	___
11. Have you ever been knocked unconscious?	___	___
12. Do you have frequent headaches?	___	___
13. Have you ever had seizures?	___	____
14. Do you have epilepsy?	___	___
15. Do you have diabetes?	___	___
16. If female, is menstrual history abnormal?	___	___
17. Have you had frequent ear infections?	___	___
18. Do you have any skin problems (rash, acne, etc.)?	___	___
19. Is there a history of bed wetting?	___	___
20. Is an orthodontic appliance being brought to camp?	___	___
21. Do you wear glasses, contacts or protective eye wear?	__	___

**If you answered yes to any of the above, please provide details on another page.*

Attention Parent: Please attach copy of camper's health insurance card to this form.

PHYSICIAN SECTION

** Please review the information on both sides of this page and complete the questions below. Use additional sheets as necessary.*

1. I have reviewed this entire medical form and confirm that all information herein and on any attached pages is correct____ should be clarified as follows:

2. The above person is___ is not___ able to participate in an active camping program.
3. The applicant is under the care of a physician for the following conditions:

   Current treatment includes:

4. Recommendations and restrictions at camp:

5. Treatment to be continued at camp:

6. Medications to be administered at camp (see attached sheet):

7. Any medically prescribed meal plan or dietary restrictions:

8. Any allergies to be noted:

Physical exam

Date of last examination_____
Height_____Weight_____B.P._____

Immunization history:

Vaccine	up to date	yes	no
Measles		___	____
Mumps		___	____
Rubella		___	____
Chickenpox		___	____
*Tetanus		___	____
Hepatitis B		___	____
Diptheria		___	____
Pertussis		___	____
Polio		___	____

*Date of last tetanus shot is required

Physician's Signature_____Date_____Printed Name_____

Address_____City_____State_____Zip_____

Phone_____Form completed by_____Date_____

Joel Ross Tennis Camp

NON-PRESCRIPTION AUTHORIZATION FORM

Parent & Physician must initial each approved non-prescription medication on line provided & write full signature on back page.

Camper's Name_____Age_____Weight_____

Acetaminophen: tablets (i.e. Tylenol Regular Strength) 325 mg. ea.
elixir (80 mg. per 1/2 tsp)

purpose: pain reliever/fever reducer
dosage: <110 lbs...1 tablets every 4-6 hours as needed; not to exceed 4 tablets in a 24 hour period
>110 lbs...2 tablets every 4-6 hours as needed; not to exceed 8 tablets in a 24 hour period
or Elixir ...60-71 lbs: 2 1/2 tsp...; 72-95 lbs: 3 tsp...every 4 hours as needed; not to exceed 5 doses in 24 hour period

Parent's Initials_____ **Physician's Initials**_____

Ibuprofen tablets (i.e. Advil) 200 mg. ea.
oral suspension (i.e. Children's Advil) 100 mg. per tsp.

purpose: pain reliever/fever reducer
dosage: <110 lbs...1 tablet every 4-6 hrs.; not to exceed 4 tablets in 24 hr. pd.
>110 lbs...2 tablets every 4-6 hrs; not to exceed 4 tablets in 24 hr. pd.
for children 60-71 lbs: 2 1/2 tsp...72-95 lbs: 3tsp...every 6-8 hours as needed but no more than 4x a day

Parent's Initials_____ **Physician's Initials**_____

Guaifenesin syrup (i.e. Robitussin) 100 mg. per tsp.

purpose: loosens & relieves chest congestion
dosage: <110 lbs.....1 1/2 tsp every 4 hours
>110 lbs...3 tsp every 4 hours

Parent's Initials_____ **Physician's Initials**_____

Pepto-Bismol chewable tablets or liquid

purpose: relief for upset stomach, indigestion, nausea, heartburn, diarrhea
dosage: <110 lbs.....1 tablet (or 1 tbsp) every 1/2 to 1 hour as needed; max of 8 doses in 24 hr. pd.
>110 lbs...2 tablets (or 2 tbsp) every 1/2 to 1 hour as needed; max of 8 doses in 24 hr. pd.

Parent's Initials_____ **Physician's Initials**_____

Mylanta liquid

purpose: antacid-anti-gas
dosage: >110 lbs...shake well, take 3 tsps. between meals; not to exceed 24 tsps. in 24 hr. pd.

Parent's Initials_____ **Physician's Initials**_____

Dramamine chewable tablets 50 mg. ea.

purpose: motion sickness
dosage: <110 lbs...1 tablet every 6-8 hours, not to exceed 3 tablets in 24 hr. pd.
>110 lbs...2 tablets every 4-6 hours, not to exceed 8 tablets in 24 hr. pd.

Parent's Initials_____ **Physician's Initials**_____

Camper's Name_____Age_____Weight_____

Pseudoephedrine HCL tablets (i.e. Dimetapp) 120 mg. ea.

purpose: relieves nasal & sinus congestion due to colds & allergies
dosage: >110 lbs...1 caplet every 12 hours not to exceed 2 caplets in 24 hrs.

Parent's Initials_____ **Physician's Initials**_____

Diphenhydramine HCL (i.e. Benadryl) tablets 25 mg. ea.; liquid 12.5 mg. per tsp.

purpose: relief from allergic reactions i.e. stuffy, runny nose, sneezing, itchy, watery eyes, itchy throat
dosage: <110 lbs...1 tsp. every 4-6 hrs.; do not take more than 6 doses in 24 hr. pd.
>110 lbs...2 tsp liquid or 1 tablet every 4-6 hrs.; do not exceed 6 tablets (6 doses) in 24 hr. pd.

Parent's Initials_____ **Physician's Initials**_____

Immodium caplets (each contains 2 mg Ioperamide HCL)

purpose: diarrhea
dosage: <110 lbs...1 caplet after the first loose stool; 1/2 caplet after each subsequent loose stool; no more than 3 caplets in 24 hours
>110 lbs...2 caplets after the first loose stool; 1 caplet after each subsequent loose stool; no more than 4 caplets in 24

Parent's Initials_____ **Physician's Initials**_____

Bacitracin ointment

purpose: prevention of infection in minor cuts, scrapes, burns
directions: apply small amount to affected area 1-3x daily

Parent's Initials_____ **Physician's Initials**_____

Caladryl lotion

purpose: relief from poison ivy
dosage: shake well; wash affected area; apply no more than 3-4x daily

Parent's Initials_____ **Physician's Initials**_____

Hydrocortisone cream 1%

purpose: relief of itching from minor skin irritations, inflammation & rashes
directions: apply to affected area no more than 3-4x daily

Parent's Initials_____ **Physician's Initials**_____

Parent & Physician full signature below:

Parent's Signature_____Date_____

Physician's Signature & Title_____Date_____

before June 20: JRTC PO Box 62H Scarsdale, NY 10583 914-723-2165 fax 914 723 4579
after June 20: JRTC Kent School PO Box 6006 Kent CT 06757 fax 860-927-6339

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PRESCRIBED MEDICATION AUTHORIZATION FORM

Part 1 must be signed by physician
Part 2 must be signed by parent

1. AUTHORIZATION BY PHYSICIAN:

Name of Child_____Date of Birth_____/_____/_____
Street Address_____City_____State_____
Condition for which drug is being administered during camp hours_____
_____
DRUG: Name of Drug, Dose and Method of Administration_____
_____
Times of Administration: _____,_____,_____ Medication shall be administered from ____/____/____-
____/____/____
Relevant side effects to be observed, if any_____
_____

If there are side effects, plan for management_____
_____
Is this a controlled
drug?_____
Allergies, reaction to, or negative interaction with food or drugs? If YES, list_____
_____
The authorized prescriber's (Doctor) or Dentist's Name_____Phone
#(____)_____
Street Address_____City_____State_____

PHYSICIAN'S SIGNATURE _____**Date** _____/_____/_____

PHYSICIAN'S PRINTED NAME_____

2. AUTHORIZATION BY PARENT for the administration of the above medication:

I hereby request that the above medication, ordered by the authorized prescriber/dentist for my child_____, be administered by the nurse or by camp personnel with current Medication Administration Training.

I understand that I must supply the Youth Camp with the prescribed medication in the original container dispensed and properly labeled by an authorized prescriber, dentist or pharmacist. Over the counter medications shall be in the original container labeled by the parent with the child's name. I understand that this medication will be destroyed if it is not picked up within one (1) week following termination of the order.

Name of Parent or
Guardian_____**Signature**_____

Relationship to child_____**Date** _____/_____/_____

CONFIDENTIAL INFORMATION FORM & DISCLOSURE STATEMENT

_____

PLEASE ATTACH RECENT WALLET SIZE PHOTO HERE!

A special note regarding this form:

Many parents are ambivalent about providing camps with information about personal aspects of their child's behavior or past experience. Some parents fear that the information may be misused, while others are concerned about their child being 'labeled', singled out or treated differently. All parents want to see their child have a good start at camp, unencumbered by past problems.

Very often having prior knowledge about a learning difficulty or a recent loss in or out of the family or a major change in the family or in the child's life can be the crucial factor in helping us be sensitive to your child's need for patience, understanding and reassurance. Since children often automatically use their behavior rather than their words to tell us what is bothering them, having advance knowledge of areas that might be difficult for your child really helps us understand the message in his or her actions so we can assure him or her of a better summer.

Our commitment is never to misuse such information or to release it to unauthorized persons. It will never be used at camp unless necessary and then only with the greatest of discretion. If you wish, we will inform you of any need to share this information with the staff people who are most in contact with your child and will certainly let you know if your child is having difficulty. If you have any special concerns about this information or about your child, please feel free to call or write us. As a team we can better assure your child of a successful time at camp.

Camper's Name_____ Grade (beginning 9/19)___

First Time Camper_____ Has Been Away_____

Allergies and/or medical problems (just list them here and we will check the medical form for the details):

Any information you can furnish us with, regarding your child's personality traits, relationships with peers and adults, fears, etc. would be most helpful in assuring him/her a happy and productive summer (use other side as necessary):

DISCLOSURE STATEMENT: By signing below, the parent guarantees full disclosure of important camper issues in space provided above.

Parent Signature_____Date_____

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Behavior Contract

When campers are respectful of the environment & one another the Joel Ross 'experience' can be amazing.

Our campers must understand that they are accountable for their actions and to accept the consequences of inappropriate behaviors.

Below are some examples where parents may be called or campers may even be sent home without refund:

- Misbehavior & Bullying which includes but not limited to:
  hitting, 5 starring, punching, threatening, aggressive behavior, nut tapping
  verbal abuse, teasing, excluding, name calling,
  pranking or hazing of any nature
- Inappropriate sexual behavior
- Sleeping through meals or activities
- Being in the dorm rooms during activity periods or meals
- Stealing; destroying camp or camper property
- Sneaking out of dorm after curfew...camper is sent home the next day
- Sneaking cell phone into dorm room...camper is sent home that day
- Racial, ethnic slurs
- Possession of cigarettes, e-cigarettes, illegal drugs or alcohol, matches, weapons, etc.
- General disrespect of campers, staff or the environment

These are just examples & not the only reasons that parents may be called or campers may be sent home without refund.

We require that both a parent & the camper sign & return to us before camp.
The undersigned understand the above contract & agree to be bound by the same.

Parent's Signature_____ Date _____

Camper's Signature_____ Date _____

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Camper's Name_____ **Session(s)**_____

1. General Activity/Trip Permission Form

I give my child permission to participate in camp sponsored activities and trips i.e. (but not limited to) tennis, squash, golf, basketball, soccer, football, softball, fitness including weights, archery, fishing, walks to town, etc.

Trip to bowling: July 5, 19 depart 7pm; return 9:30pm
Trip to movies: July 10, 24 depart 6pm; return 9:30pm
Trip to Danbury Mall for 10th - 12th graders: July 8, 22 depart 6pm; return 10:30pm

For campers staying between sessions 1 & 2 and 2 & 3:
Trip to Danbury Mall July 12, 24 depart 3pm; return 8pm
Trip to Lake Compounce Amusement Park July 13, 25 depart 10am; return 7pm

Parent's Signature_____ **Date** _____

2. Camper's E-Mail: please provide the camper's e-mail address below:

Camper's E-Mail: _____

3. Credit Card for incidental charges i.e. restringing, doctor visit, medicine, camp logo items, etc.

Visa or Mastercard #:_____**Expiration**_____**3 digit CVC#** _____

Please return these completed forms