

**NEW YORK STATE SHERIFFS' INSTITUTE, INC****2026 SUMMER CAMP APPLICATION**

Week \_\_\_\_\_

This page is to be filled in by Parent or Guardian of camper. Complete all questions. PLEASE PRINT CLEARLY.

Camper Name \_\_\_\_\_ County \_\_\_\_\_

Birth date \_\_\_\_\_ Age on July 1, 2026 (must be 9,10,11 or 12) \_\_\_\_\_ Gender \_\_\_\_\_ Grade \_\_\_\_\_

Parent or Guardian \_\_\_\_\_

Phone: Home (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_ Relation to camper \_\_\_\_\_

Email(s) \_\_\_\_\_

Home Address \_\_\_\_\_

If parent or guardian is not available, please list 2 additional contacts in case of emergency (REQUIRED):

1. Name \_\_\_\_\_ Relation \_\_\_\_\_ Phone \_\_\_\_\_  
2. Name \_\_\_\_\_ Relation \_\_\_\_\_ Phone \_\_\_\_\_

**HEALTH HISTORY (Please indicate with an X)**

Medications \_\_\_\_\_ Inhaler \_\_\_\_\_ EpiPen \_\_\_\_\_ Allergies \_\_\_\_\_ Bed wetter \_\_\_\_\_

Please answer all these questions. Do not leave any answers blank. Write "None" if there is none.

Physical Health Issues/Diagnosis \_\_\_\_\_

Mental Health or Behavioral Issues/Diagnosis \_\_\_\_\_

Medications that will be brought to camp (detailed info to be provided by doctor on Page 4) \_\_\_\_\_

Additional Information Camp should know about \_\_\_\_\_

**\*\*\*\*\*PARENT/GUARDIAN AUTHORIZATION (required)\*\*\*\*\***

This health history is correct so far as I know, and the person described herein has permission to engage in all prescribed camp activities, except as noted by me and the examining physician. In the event I cannot be reached in an EMERGENCY situation, I hereby give permission to the physician selected by the Camp Director to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child named above. In addition, I give permission to the NYS Sheriffs' Institute, Inc. to use pictures taken of my child while attending summer camp. I also authorize my child to carry and apply sunscreen and/or bug spray as necessary. If needed, camp staff may help my child apply either.

I will notify camp if this camper is exposed to any communicable diseases during the 3 weeks prior to attending camp.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**THIS PAGE IS TO BE COMPLETED, SIGNED AND DATED BY PHYSICIAN/ PA/ NP.**

Camper Name \_\_\_\_\_ County \_\_\_\_\_ Week \_\_\_\_\_

**IMMUNIZATION HISTORY- An immunization summary from a medical office can be submitted instead of filling in dates below.**

\_\_\_\_\_ Diphtheria, Tetanus and Pertussis Vaccine (DTP, DtaP)

\_\_\_\_\_ Tetanus, Diphtheria and Pertussis Booster(Tdap)

\_\_\_\_\_ Polio (IPV or OPV)

\_\_\_\_\_ Varicella

\_\_\_\_\_ Measles, Mumps, Rubella (MMR)

\_\_\_\_\_ Meningococcal (Recommended/not required)

\_\_\_\_\_ Hepatitis B

\_\_\_\_\_ Covid 19 Vaccine (Recommended/not required)

**This examination must be performed within 12 months of arrival at camp. Physical examination for some other purpose within this period is acceptable. Examination is for determining fitness to engage in strenuous activities.**

**CODE: S- satisfactory X- not satisfactory O- not examined**

Height \_\_\_\_\_ Weight \_\_\_\_\_ BP \_\_\_\_\_

Hgb test \_\_\_\_\_ Urinalysis \_\_\_\_\_

Eyes \_\_\_\_\_ Glasses \_\_\_\_\_

Extremities \_\_\_\_\_

Ears \_\_\_\_\_

Posture (Spine) \_\_\_\_\_

Nose \_\_\_\_\_

Skin \_\_\_\_\_

Throat \_\_\_\_\_

Allergy \_\_\_\_\_

Teeth \_\_\_\_\_

Specify Allergies \_\_\_\_\_

Heart \_\_\_\_\_

General Appraisal \_\_\_\_\_

Lungs \_\_\_\_\_

\_\_\_\_\_

Abdomen \_\_\_\_\_

\_\_\_\_\_

Hernia \_\_\_\_\_

\_\_\_\_\_

For Girls: Has this person menstruated? \_\_\_\_\_

If not, has she been told about it? \_\_\_\_\_

If yes, is her menstrual history normal? \_\_\_\_\_

Special considerations? \_\_\_\_\_

**Recommendations and restrictions while at camp:**

Special Diet \_\_\_\_\_

Will medications be sent to camp? \_\_\_\_\_ If yes, page 4 must be completed with details.

Able to swim? \_\_\_\_\_

Participate in strenuous activity? \_\_\_\_\_

Other recommendations and/or restrictions? \_\_\_\_\_

**I have examined the person described herein and have reviewed his/her health history. It is my opinion that he/she is physically able to engage in camp activities, except as noted above.**

Physician/PA/NP Signature and Title \_\_\_\_\_ MD PA NP (circle one)

Date of physical \_\_\_\_\_

Date form completed \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

## Over- the Counter Medications/Topicals Permission

The following medications/topicals will be available for common ailments/complaints campers may experience while at camp. We are only able to dispense if we have medical permission. Please indicate whether the medications listed may be dispensed to your camper, and sign the bottom, along with medical staff signature.

Please note that the 3 Required topicals which are indicated below are mandatory for your camper's application to be accepted.

Parents will be notified before the use of any of these over- the-counter medications/topicals.

Any other Over-the-Counter medications not listed on this form will need to be included on the Page 4 Medication Form that is also used for all Prescription Medications.

Medication	Yes (Y) or No (N)	Medication	Yes (Y) or No (N)
First Aid/ Neosporin Cream	Y - Required	Sterile Eye Wash	Y N
Aloe/Burn Gels	Y - Required	Eye Drops	Y N
Calamine/Caladryl Lotion	Y - Required	Ear Drops	Y N
Anti Itch Spray	Y N	Vaseline for Dry Lips	Y N
Hydrocortisone Cream	Y N	Tums	Y N
Hurt Free Antiseptic Liquid	Y N	Throat/cough lozenges	Y N

Parent/Guardian Name Printed \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_

Physician/PA/ NP Name \_\_\_\_\_

Physician/PA/ NP Signature \_\_\_\_\_

Date Sheet Filled Out \_\_\_\_\_

Camper Name \_\_\_\_\_ County \_\_\_\_\_ Week # \_\_\_\_\_

### Prescription and additional Over-the-Counter Medication Detail

All Medications (prescription and over-the-counter) must be in original bottles, with original labeling and packaging. All medications (prescription and over-the-counter) must be detailed on this sheet and authorized by a physician/PA/NP. We are unable to accept loose, unlabeled, or unpackaged medications. Please be sure to include any inhalers or epi-pens, along with the reason for them. We are unable to dispense any medications (prescription and over-the-counter) that are not authorized by a physician/PA/NP.

Details below must include the name of the medication (prescription and over-the-counter), the dosage indicated, the time of day to be dispensed and the reason for the medication. Also, please indicate if medication needs to be taken with food. If taking more than 7 medications, please make a copy of this sheet and submit both sheets signed by guardian and physician/PA/NP.

Make a copy of this form to include in a zip-lock bag with your camper's medications. Include an updated form if there have been any medication changes since application. Clearly label this bag with your child's name and county. This bag will be given to the camp nurse upon arrival.

Name of Medicine	Dosage to be taken and Time of Day	Reason for Medicine	Taken with food?

Parent/Guardian Name Printed \_\_\_\_\_

Date sheet filled out \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_

Physician/PA/ NP Name \_\_\_\_\_

Physician/PA/ NP Signature \_\_\_\_\_