



## Manice Education Center Application Checklist 2011

Please Read and Complete the Following Forms:

### **ALL FORMS ARE DUE TO CHRISTODORA NO LATER THAN TWO WEEKS PRIOR TO YOUR STUDENT'S DEPARTURE DATE TO THE MANICE EDUCATION CENTER.**

Please send or give your child's forms directly to the Christodora office:  
1 East 53<sup>rd</sup> Street #1401, New York, NY 10022 - Fax (212) 371-2111

- Scholarship Application**
  - This form is to be completed by the parent/guardian and must be completed in order to be considered for assistance with the tuition.
    - Also send in your W2 forms or any proof of income.
- MEC Summer Parent/Guardian Permission Slip**
  - This form is to be filled out and signed, where appropriate, by a parent/guardian. This form must be given to a Christodora-Manice Education Center staff member for your student's summer program.
- MEC Summer Student Information, Rules, and Responsibilities Form**
  - This form is to be read and signed by both the parent/guardian and student.. This form must be given to a Christodora-Manice Education Center staff member for your student's summer program.
- Submission of the \$60 registration fee**
- Transportation and Release Authorization**
  - This form is to be filled out and signed, where appropriate, by a parent/guardian. This form must be given to a Christodora-Manice Education Center staff for your student's summer program.
  - If a parent/guardian or authorized escort will be picking up your student at the end of their summer program, they will need photo ID and must sign for the release of your student.
- Health Record, Examination and Medical Release Form**
  - This form consists of two parts. A parent/guardian is required to fill out pages 1-3 and sign, where appropriate. A licensed medical provider will need to examine your student, review pages 2 -3, and fill out page 4.
  - If there are any changes to your student's health or medications after you have submitted this form, please contact the Christodora office. It is important that we are aware of the most current medical information about your student to best provide care during their stay.
- Authorization to Administer Medication to a Student**
  - This form is to be filled out and signed, where appropriate, by a parent/guardian. This form must be given to a Christodora-Manice Education Center staff member for your student's summer program. **Your student will not be allowed on the bus if medication is not in original packages from your pharmacy.**
  - **If any medications listed on the Health Record and/or Authorization to Administer Medication Forms have changed from the time you submitted them, a parent/guardian must sign a new Authorization to Administer Medication Form on the day of departure. Please be sure to inform a staff member at departure you need to update and sign a new form! We cannot administer medications without this updated authorization.**

Additional information about our programs is available at [www.christodora.org](http://www.christodora.org) or by contacting admissions at 212-371-5225 or emailing [admissions@christodora.org](mailto:admissions@christodora.org).



# Manice Education Center Health Record, Examination and Medical Release Form

The following information is requested to assist Christodora-Manice Education Center in providing appropriate care for your student. Each student's Health Record and Examination Form is REQUIRED TO BE SUBMITTED 2 WEEKS PRIOR TO THE DEPARTURE DATE for your student's attendance to the Manice Education Center. A Physical Examination and a review of the Health History is also required to be completed by an approved licensed medical provider within 24 months prior to participation in a Christodora-Manice Education Center program. We treat all personal medical information with confidentiality. A student's medical information is securely stored and will be shared only with pertinent program staff and medical providers.

Student Name \_\_\_\_\_ Birth date \_\_\_\_\_ Age at camp \_\_\_\_\_

Home Address \_\_\_\_\_  
 Street Apartment City State Zip

Social security number of participant \_\_\_\_\_  Male  Female

Parent/Guardian \_\_\_\_\_ Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_

Home Address \_\_\_\_\_  
 (if different from above) Street Apartment City State Zip

Business Address \_\_\_\_\_ Work phone \_\_\_\_\_  
 Street City State Zip

**If parent/guardian not reachable in an emergency notify:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Best number to reach \_\_\_\_\_

Address \_\_\_\_\_ Work or Cell phone \_\_\_\_\_

**Insurance Information**

Is the participant covered by a work/family/individual medical/hospital insurance?  Yes  No

Insurance Carrier/Plan Name \_\_\_\_\_ Group/Policy # \_\_\_\_\_

**➔ Please attach a copy of the front and back of health insurance card.**

**Authorization for Participation:** section must be read, filled out, and signed by parent or guardian for participant attendance.\*

I hereby give permission to the Manice Education Center (MEC) trained staff to administer standard first aid, including over the counter medications unless I listed any restrictions herein. I hereby give permission to the MEC staff to administer all prescription medication I have provided to MEC for my student while at MEC. I hereby give permission to the medical personnel selected by the MEC Director, Assistant Director, Field Teacher or designate to order x-rays or other routine tests and treatment for my student, and in the event I cannot be reached in an emergency, I hereby give my permission to the physician selected by the above mentioned to hospitalize, secure proper treatment for and to order injection and/or anesthesia and/or surgery for my student as named above. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to MEC to arrange necessary related transportation for this participant. This completed form will be photo copied for offsite trips.

\_\_\_\_\_  
**Parent/Legal Guardian Signature**

\_\_\_\_/\_\_\_\_/\_\_\_\_  
**Date**

*\*If for religious reasons you cannot sign and authorize this form, contact Christodora for a waiver to sign for attendance.*

**Health History**

The following Health History information must be filled out by the **parent/guardian** and reviewed by the **examining licensed medical provider**. Please provide complete information so that the Christodora-Manice Education Center can be aware of your youth participant's entire needs.

Yes No

Si No

Had any recent injury or infectious disease		Ha sufrido alguna lesión reciente/enfermedad infecciosa		
Have chronic recurring illness/condition		Tienen una enfermedad crónica recurrente/condición		
Ever been hospitalized		Ha sido hospitalizado		
Ever had surgery		Alguna vez ha sufrido cirugía		
Have frequent headaches		Sufre de dolores de cabeza frecuentes		
Ever had a serious head injury		Alguna vez ha sufrido una lesión grave en la cabeza		
Ever had frequent ear infections		Alguna vez ha sufrido infecciones de oído frecuentes		
Ever passed out during exercise		Alguna vez se desmayó durante el ejercicio		
Ever had seizures		Alguna vez ha sufrido convulsiones		
Ever had chest pain during exercise		Alguna vez ha sufrido dolor en el pecho durante el ejercicio		
Ever had/have high blood pressure		Alguna vez tuvo / tiene la presión arterial alta		
Ever had a diagnosis of heart murmur		Alguna vez tuvo un diagnóstico de soplo en el corazón		
Ever had serious back problems		Alguna vez ha sufrido serios problemas de espalda		
Ever had serious joint problems		Alguna vez ha sufrido serios problemas en las articulaciones		
Have any skin problems		Tiene problemas de la piel		
Had mononucleosis in past year		Sufrido mononucleosis en el último año		
Had serious digestive problems		Ha sufrido de graves problemas digestivos		
Have problems with sleep walking		Ha sufrido de problemas con el sonambulismo		
Have history of or currently bed wetting		Tiene una historia de actualidad o de mojar la cama		
Have or had eating disorder		Sufre o ha sufrido trastornos alimenticios		
Wear eye glasses or contacts		Usa gafas o contactos		
Have orthodontic appliance		Usa aparato de ortodoncia		
Have an abnormal menstrual history		Si es mujer, tiene una historial de menstruacion normal		
Have or had emotional difficulties		Sufre o ha sufrido dificultades emocionales		
Have diabetes		Sufre de diabetes		
Have asthma		Sufre de Asma		

Please explain any **Yes** answers above:

**\*\*Si su respuesta fue "si" para alguna pregunta anterior, favor de explicar en el formulario adjunto.\*\***

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**Current Medication Being provided:**

This student takes NO medication on a routine basis at this time, and is bringing no medication to camp.

This student takes medication as follows:

Name of Med #1 \_\_\_\_\_ Dosage \_\_\_\_\_ Frequency \_\_\_\_\_  
Reason for taking: \_\_\_\_\_

Name of Med #2 \_\_\_\_\_ Dosage \_\_\_\_\_ Frequency \_\_\_\_\_  
Reason for taking: \_\_\_\_\_

Name of Med #3 \_\_\_\_\_ Dosage \_\_\_\_\_ Frequency \_\_\_\_\_  
Reason for taking: \_\_\_\_\_

Name of Med #4 \_\_\_\_\_ Dosage \_\_\_\_\_ Frequency \_\_\_\_\_  
Reason for taking: \_\_\_\_\_

Our trained staff will administer applicable over the counter medications for first aid treatments and minor ailments, and/or including sunscreen and insect repellent for all participants to the Christodora-Manice Education Center. **Please list any over the counter medications your student is allergic to or may not take due to an undesirable medical interaction with their current prescribed medications and the reason why.** You are responsible for listing only the over the counter medications your student may not take.

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**Allergies:**

Medication allergies \_\_\_\_\_ Medication taken (if any), reaction and management of reaction \_\_\_\_\_

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Food allergies \_\_\_\_\_ Medication taken (if any), reaction and management of reaction \_\_\_\_\_

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Other environmental /seasonal/ insect \_\_\_\_\_ Medication taken (if any), reaction and management of reaction \_\_\_\_\_

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**Restrictions and other considerations:**

Dietary: (does not eat, allergic to, special diet because...)

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Activity: (due to recent or chronic medical conditions, adaptations, or limitations...)

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Please use this space to provide additional information about the participant (physical, mental, emotional, behavior) that you feel the camp should be aware of and may assist in provide safe and beneficial participation in the program.

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**Immunization History:**

	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Participant had or has:	Dates (if available):
DTP					Hepatitis C	
TD (tetanus/diphtheria)					Measles	
Tetanus					Chicken pox	
Polio					German measles	
MMR					Mumps	
Or measles					Hepatitis A	
Or mumps					Hepatitis B	
Or Rubella					Rheumatic Fever	
Haemophilus influenza B					Seizures	
Hepatitis B					Diabetes	
Varicella (chicken pox)					Asthma	
Pneumococcal Conj. PCV)						
Other						

Name of family physician \_\_\_\_\_ phone \_\_\_\_\_

Address \_\_\_\_\_

Name of dentist/orthodontic \_\_\_\_\_ phone \_\_\_\_\_

Address \_\_\_\_\_

**Medical Examination:**

**To be filled out by an approved licensed medical provider**

I have examined the individual on this date: \_\_\_\_\_

Height:\_\_\_\_\_ Weight:\_\_\_\_\_ Blood pressure:\_\_\_\_\_

The applicant is under the care of a physician for the following conditions:\_\_\_\_\_

Treatment to be continued at camp:\_\_\_\_\_

Description of any limitation or restriction on camp activities:\_\_\_\_\_

Additional information for health care staff at the camp:\_\_\_\_\_

➔ Attach additional examination results as available.

I have examined the person herein described and reviewed his/her health history.	
In my opinion, the above person <input type="checkbox"/> <b>is</b> <input type="checkbox"/> <b>is not</b> (check one) able to participate in active camp programs.	
Signature of Licensed Medical Personnel: _____	Date _____
Printed name: _____	Title _____
Health Care Organization/Clinic name: _____	
Address: _____	
Phone: _____	Fax: _____



## Manice Education Center Authorization to Administer Medication to a Student

**\*\*Please note that you *must* submit all medications, prescription or over the counter, in the original containers bearing the directions for use and the pharmacy and patient information!\*\***

Student Name \_\_\_\_\_

	Med 1:	Med 2:	Med 3:	Med 4:
Dosage				
Frequency				
Expiration Date				
Administration	<input type="checkbox"/> Oral <input type="checkbox"/> Topical	<input type="checkbox"/> Oral <input type="checkbox"/> Topical	<input type="checkbox"/> Oral <input type="checkbox"/> Topical	<input type="checkbox"/> Oral <input type="checkbox"/> Topical
Quantity at Camp				
Specific Directions				
Specific Precautions				
Possible Side Effects				

I understand that Christodora-Manice Education Center does not assume responsibility for any medication you have not appropriately listed. I also understand that I must report any non-prescription medications my student is not permitted to take. I hereby authorize Christodora-Manice Education Center to administer to my student the medication(s) listed above, in accordance with 105 CMR 430.160.

105 CMR 430.160 (A) Medication prescribed for campers shall be kept in original containers bearing the pharmacy label, which shows the date of filling, the pharmacy name and address, the filling pharmacist's initials, the serial number of the prescription, the name of the patient, the name of the prescribing practitioner, the name of the prescribed medication, directions for use and cautionary statements, if any, contained in such prescription or required by law, and if tablets or capsules, the number in the container. All over the counter medications for campers shall be kept in the original containers containing the original label, which shall include the directions for use.

105 CMR 430.160 (C) Medication shall only be administered by the health supervisor or by a licensed health care professional authorized to administer prescription medications. If the health supervisor is not a licensed health care professional authorized to administer prescription medications, the administration of medications shall be under the professional oversight of the health care consultant. The health care consultant shall acknowledge in writing a list of all medications administered at the camp. **Medication prescribed for campers brought from home shall only be administered if it is from the original container, and there is written permission from the parent/guardian.**

105 CMR 430.160 (D) When no longer needed, medications shall be returned to a parent or guardian whenever possible. If the medication cannot be returned, it shall be destroyed.

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<b>Parent/Legal Guardian Signature</b>	<b>Date</b>
<b>If your student carries an inhaler for asthma and/or an epi-pen for allergies, please read and sign below</b>	
	_/_/_
<b>Parent/Legal Guardian Signature</b>	<b>Date</b>