Middlesex County Camp

298 East Haddam Moodus Road
Moodus, Connecticut 06469
Tel: (860) 873-2294

2017 Health History and Record of Physical Exam

(This section should be completed by a parent/ guardian or adult camper/staff)

Campers Name:_____ Date of Birth: _____ Age at camp:_____
Last First

Home address:_____
Number & Street City State Zip

Custodial parent/ guardian or spouse:_____ Phone: ( ) _____

Home address:_____
(if different from above) Number & Street City State Zip

Home Phone_____ Work Phone_____ Cell Phone_____

Second parent/guardian or emergency contact:_____

Address:_____
Number & Street City State Zip

Home Phone_____ Work Phone_____ Cell Phone_____

Emergency Contact:_____ Relationship:_____

Home Phone_____ Work Phone_____ Cell Phone_____

Insurance Information

Medical Insurance Carrier:_____ Policy Number: _____

Name of Insured_____ Relationship to participant_____

(* A photocopied copy of insurance card front & back must be attached to this form*)

IMPORTANT: This must be completed for attendance

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted.

Emergency Authorization: I hereby give permission to the medical personnel selected by the Camp Director to order x-rays, routine test and treatments 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 hospitalize, secure proper treatment for, and to order injection, anesthesia and/or surgery for me/ or my child as named above. I agree to the release of any records necessary for treatment, billing, referral, or insurance purposes.

Signature of parent/ guardian or adult camper/staff member:_____ Date:_____

I also understand and agree to abide with any restrictions placed on participation in camp activities

Signature of camper/staff member_____ Date: _____

(If for religious reasons you cannot sign this, then the camp should be contacted for a legal waiver that must be signed for attendance)

Health History

Allergies

Food allergies	Reaction	Treatment
Medication allergies	**Reaction**	**Treatment**
Other allergies (bee stings, seasonal, etc.)	**Reaction**	**Treatment**

Dietary restrictions or preferences: _____

Disability or chronic illness: _____

General Questions (check yes or No)	Yes	No	General Questions (Check Yes or No)	Yes	No
Asthma			Back problems		
Diabetes			Recent illness or infectious disease		
Seizure Disorder			History of bed-wetting		
Bleeding/Clotting Disorder			Eating disorder		
Heart disease			Emotional disorder		
Frequent headaches			Diarrhea/constipation		
Frequent ear infections/ "swimmer's ear"			Sleepwalking		
Hospitalization			Abnormal menstrual history		
Surgery			Orthodontic appliance		

Please explain "yes" answers below:

_____

_____

_____

Please provide any further information concerning behavior and physical, emotional or mental health that the camp should be aware of in the space below.

_____

_____

_____

Name of family physician _____ Phone: ( ) _____

Address _____

Name of family dentist/orthodontist _____ Phone: ( ) _____

Address _____

The following over-the-counter medications are stocked in the health center in the event that you/your child should require them. These medications are administered by a Registered Nurse under the direction of our Camp Physician.

Acetaminophen	Ibuprofen	Throat lozenges	Hydrocortisone 1% Cr.
Bacitracin ointment	Ora-gel	Benadryl (Diphenydramine)	Tums
Robitussin cough syrup	Hydrogen peroxide	Calagel/calamine lotion	Eyewash solution

_____ I hereby give permission to Middlesex County Camp medical personnel to administer any of the above medication per the Standing Orders of the Camp Physician.

_____ I hereby give permission to Middlesex County Camp medical personnel to administer any of the above medication per the Standing Orders of the Camp Physician with the following exception _____

_____.

Signature parent/guardian: _____ Date: _____
(or participant if 18 or older)

Record of Physical Exam **(must be within 24 months of camp attendance)**

(This section to be completed by licensed medical provider. May attach blue State Health Assessment)

Campers Name:_____Date of Birth:_____Date of Examination:
_____Last First

Height:_____Weight:_____B/P: _____

Immunization History

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DTP						
TD/TDaP						
Polio						
MMR						
Hep B						
Varicella						

TB Mantoux Test Date	Results

Recommendations and Restrictions at Camp

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

_____

_____

Treatment to be continued at camp _____

_____

Does the camper have allergies to medicine? Yes/ No Explain: _____

Does the camper take medications? Yes/ No **** If Yes, please complete the **Camper Medication Form** on other side****

Are there any Restrictions or Recommendations while at camp? _____

Comments:

_____

_____

_____

_____ **This camper may participate in all camp activities**

_____**This camper may participate except for:** _____

Signature of Licensed Medical Personnel______

Printed:_____ Title_____
Address: _____
City, State, Zip:_____
Telephone: ( ) _____

Phone: 860 873 2294 *Fax: 860 873 2996*

AUTHORIZATION FOR ADMINISTRATION OF MEDICATIONS BY THE YOUTH CAMP PERSONNEL

In Connecticut, licensed Camps administering medications to children shall comply with all requirements regarding the Administration of Medications described in the CT State Statutes and Regulations. Parents/guardians requesting medication administration to their child while at camp shall provide the program with appropriate written authorization(s) and the medication before any medications are administered. Medications must be in the original container and labeled with child's name, name of medication, directions for medication's administration, and date of the prescription. All unused medication shall be destroyed if not picked up within one week following the camper's departure at the end of camp.
Authorized Prescriber's Order (Physician, Dentist, Physician Assistant, Advanced Practice Registered Nurse):

Name of Child _ Date of Birth _ /__ / Today's Date _ _/_ /_

Medication Name_____Controlled Drug? YES NO

Dosage_____Method_____Time of Administration _____

Specific Instructions for Medication Administration _____

Medication Administration: Start Date_____/_____/_____Stop Date_____/_____/_____

Is this medication to be self-administered by the child? [ ] Yes [ ] No

Relevant Side Effects of Medication _____

Plan of Management for Side Effects _____

Known Food or Drug Allergies? YES NO Reactions to? YES NO Interactions with? YES NO

If "yes" to any of the above, please explain _

Prescriber's Name__ Phone Number (_ _) _

Prescriber's Address _ Town _

Prescriber's Signature _

Parent/Guardian Authorization:
I request that medication be administered to my child as described and directed above.

Name of Camp _ Today's Date _ _/ /_

Child's Name _ Address_____Town_____

Name of Parent/Guardian Authorizing Administration of Medication as described and directed above:

First Name_____Last Name _____

Relationship to Child: Mother Father Guardian/Other explain: _____

Address_____Town_____Phone Number (_____) _____

Signature of Parent/Guardian Authorizing Administration of Medication _____

Name of Camp Personnel Receiving Written Authorization and Medication _____
Title/Position_____Signature (in ink) _____